

ARCHIVES OF SURGERY.

OCTOBER, 1893.

BAZIN'S MALADY. MULTIPLE ULCERS ON THE LEGS.

(Concluded from page 42, with a Plate.)

I DESCRIBED in the last number of ARCHIVES eight cases illustrating a condition which may perhaps, for the present at least, be most conveniently known as "Bazin's Malady." They are cases, as was then stated, in which multiple ulcers occur on the legs of young persons, which are probably of a more or less scrofulous nature, but which assume features much resembling syphilis. I should like to insist definitely upon the following points:—

1. That, although the most typical examples of this malady occur in young persons, and most frequently in girls, yet that the disease is not restricted either by sex or age.

2. That, although the lower extremities—the legs—are the parts most frequently affected, there is yet no positive limitation to these parts.

3. That, although definite scrofulous antecedents, or accompaniments, may be proved in some of the cases, yet there are others in which this cannot be alleged.

4. That, although the malady in well-characterised cases presents very definite peculiarities, yet that there are a great number of ill-marked cases, which are probably of the same nature, but which do not present features sufficiently definite to allow of their being grouped.

5. That, although in well-marked examples of this malady we may most definitely exclude syphilis, it is yet quite probable that in certain cases (indistinguishable by their symptoms and not to be diagnosed without risk of error even by the test of treatment), there is a double causation; and a remote taint of syphilis has to be taken into account.

It may be suspected as regards these cases that they are by no means well specialised, and that they result from a combination of causes rather than from a single one. It is scarcely probable, even in the most typical of them, and those most definitely associated with scrofula, that the sole cause is the implantation of the tubercle bacillus. Their frequent limitation to the legs is probably to be explained by the peculiarities of the circulation on those parts. Their preference for young persons, and girls in particular, is probably due to the abundance in them of subcutaneous cellular tissue. It is not unlikely that exciting causes are frequently present, such as slight injuries, thorn-pricks, or insect-stings. The essential feature in their final development is that the inflammatory products which attend them become locally infective. Upon this fact rests the explanation of their multiplicity, and upon its full recognition depends our success in treatment.

The cases, which I have already narrated, are eight in number, and seven of them occurred in girls. I shall now proceed to give the particulars of some other cases. Before doing so I may direct my readers' attention to an interesting paper on the same disease by Dr. Colcott Fox in a recent number of the "Dermatological Journal."

CASE IX.—*Multiple Ulcers on both legs in an adult woman—The arms also affected—Gland disease in neck—Liability to pustular ophthalmia—Details of treatment extending over eight years—Cure, but with tendency to relapses.*

This case is the one mentioned at p. 353 of my book on Syphilis. When the lady who was its subject first came under my observation, I was disposed to believe that it was a case of syphilis, and this diagnosis had been given by those who had previously seen her. Our suspicions were confirmed by the fact that the patient's husband admitted having

had some venereal sore before his marriage. They were further strengthened, during the course of treatment, by the fact that much improvement occurred during the use of mercury internally, as well as for the sores. I have now had this patient under my observation for eight years, and have repeatedly seen her husband and several of her children. I do not now feel any doubt that her malady was not of a syphilitic nature. The report of the case, which I published in my book in 1887, was much abbreviated; and as a number of new facts have come to my knowledge since that date, I think it may be worth while to begin at the beginning and publish now the whole of my notes concerning it. It is one of very considerable peculiarity and interest.

Mrs. D—, a lady of thirty-eight, florid and looking quite healthy, was sent to me by Dr. C—, of L—, in March, 1885. Both legs were severely affected, and she had in fact kept her bed or couch for nearly three months. On all parts of the legs, but chiefly on their backs, from a little below the knee to near the ankles, there were scattered dusky or livid indurations. Some of these were superficially ulcerated, and showed scabs; others not so; some had healed and left scars. Dr. C—'s note described them as having been "deeply punched-out, and when healing covered with a rupia-like crust." Under his treatment these characters had been much modified, but still the places had not become sound, and fresh sores still appeared. The initial lesion was always a small livid induration in the subcutaneous tissues, not a bulla. Mrs. D— herself said that none of them had ever spread much at their edges, or become what she called "running sores." We may therefore take it that none had been definitely serpiginous. There were a few small blotches above the knees. On the back of each arm, just above the elbow, was a group of dusky spots, none of them much indurated, and none ulcerated. They were clearly of the same type as those on the legs, though very much less developed. Mrs. D— had no other skin disease, but in the left side of her neck were two scars of strumous abscesses, probably glandular, one of them not yet sound.

Although Mrs. D— looked well, I was assured that, before the spots began to appear, she had been nervous and much out of health. The first sore was on the right leg and single. This was six years ago, and since then, with many periods of partial cure, they had been increasing in number. In the hope of getting rid of them, she had for three successive summers spent six weeks at Royat and submitted to vigorous water treatment. On each occasion her health had benefited, but the sores got worse. After her return home, however, the sores often nearly healed. This year they had not done so, and from her return in August to Christmas they had been getting worse. Dr. C— wrote to me that about Christmas he had prescribed the solution of perchloride of mercury with iodide, "increasing the dose to as much as she could bear, and with very good results." For six weeks, however, this treatment had been suspended, and, in spite of steel, arsenic, and ammonia, fresh places had

appeared. At Royat no specific treatment had been pursued. Thus it will be seen that the evidence from the influence of remedies was in favour of syphilis; but it must be noted that Dr. C——'s treatment, although beneficial, had by no means effected a cure, and the relapse had been very speedy when it was left off.

The facts as to syphilis in the family history were as follows: Mr. D——, her husband, had two years or so before marriage suffered from a venereal sore. So far as he remembered, it lasted only a few days, and no secondary symptoms had followed. There had been no reminders. I saw him, and he appeared quite well. They had been married thirteen years. The first conception ended in a miscarriage, the next in a live birth, and the child, a girl, was now living, and had never presented any suspicious symptoms. There were four other living children, and had been two other miscarriages. Nothing had ever been noticed in any of the children to lead to suspicion. Mrs. D—— during the early part of her married life had been quite well, but she thought that rapid child-bearing had weakened her, and after one confinement she had had a white-leg. Her youngest child was now four. There was a tubercular tendency in her family, and a sister and an uncle had died of phthisis. She herself, when a girl of eleven, was sent abroad on account of suspected lung disease, but had never since had any symptoms of it.

April 19th, 1885.—They begin as *little indurations or knots* under the skin, which are very slow in progress, but soften gradually. She has been slightly salivated, but without any definite effect on the legs. Some fresh places are coming, and some have faded. On the whole, improvement. Has been walking well.

May 13th, 1885.—The benefit from the mercury appears to have been definite and considerable. Almost all the places have healed, and she can walk with comfort. She is staying at Hastings, and going out regularly. The gums are still decidedly sore. It is to be noted that, although the ulcers have healed on the legs and the induration beneath them almost wholly disappeared, yet the little knots on the backs of the arms remain much as they were. These are placed in symmetrical groups behind each arm, just above the elbow. They are not larger than peas, and none of them ulcerated. Even on the legs, whilst most have got well, a few new ones are threatening. I suspect that the indurations begin around venules, or possibly they are lymphatic.

June 20, 1885.—Mrs. D—— afterwards stayed at Westgate-on-Sea for six weeks longer, and much improved in health. Her legs also continued to get better, and when in June she returned to L—— they were all but well. Still, however, some subcutaneous indurations persisted both in the legs and above the elbows, but they showed no tendency to break down. She had been taking specifics all the time.

October 15, 1885.—She looks well, is florid, but the legs are little or no better. The primary lesion is not always the same; some begin as hard knots under the skin, and others as bullæ or small erythematous patches

which vesicate. There are no large ulcers on the legs, but several low rupia-like scabs. The tendency to form a rupia-scab is quite definite. When the subcutaneous knots inflame, they vesicate before they ulcerate. Both upper extremities are rather worse—that is, the spots and knots are more numerous, and some of them are inflamed; none of them are large. She has taken for the last month eight grains of iodide and a drachm of Liq. Hydr. Bichl. She has lost flesh, and feels weak, although very florid and looking well. When not taking medicine, she feels perfectly well. I now advise her to try inunction of mercury to slight pytalism.

November 24, 1885.—Since October 15 she has been rubbing in half a drachm of strong mercurial ointment every night. Her health has been excellent, and there has been no pytalism or diarrhœa. The arms are nearly well, but the legs are not well. There are now no bad ulcers, but several indolent dusky sores with crusts. None of the places heal quickly. She walks about a good deal. Whilst using the Ung. Hydr. she has also been freely applying a lotion of sulphate of zinc (a drachm to ʒij). She thinks that this lotion has suited well. No pain whatever. In excellent spirits. Last winter she was in bed most of the time on account of the soreness of the legs.

February 23, 1886.—Ever since Oct. 15 we have been rubbing in half a drachm of strong mercurial ointment every night, that is for about four months. The rubbing has usually occupied half an hour, and it has been done with almost absolute regularity. The result has been that the places are almost all healed. Those on the backs of the arms have quite disappeared. On the legs the cure is not so complete, and much induration remains about some of the scars, but there are no ulcers. Mrs. D—— is in excellent health. The prolonged inunction has agreed well. She is florid, has good appetite, and sleeps well; she says that she never felt in better energy in her life. The only drawback is an occasional headache in the back of the head. Her legs now allow her to walk a great deal, and she is constantly about. Any one looking at the legs now for the first time would unhesitatingly declare them syphilitic. They are covered over the calves with depressed scars, which are dusky at their margins, and some of them having hard lumps extending into the cellular tissue around them. The question still remains, Are they syphilitic? and it is perhaps not even yet quite set at rest by the good results which have followed mercurial inunction. She had previously benefited much from change of air to the seaside and to Scotland. In November, soon after the inunction was begun, her residence was changed from L—— to a very healthy elevated spot above B——. This change seems to have suited her health well. If syphilitic, its symmetry on both arms and legs is certainly remarkable, and so is the fact that it has not yielded more definitely to specific treatment, more especially to the continued pytalism which at one period we maintained. It should be added that quite recently she has had a small abscess on the left side of her

neck. It was not apparently glandular. There is an old scar of an abscess near it, which she says occurred soon after her marriage.

June 24, 1886.—The legs and the arms have been nearly well through the winter. Has been laid up with “phlyctenular conjunctivitis,” and lost her voice. She left off using the mercurial inunction. Her legs, which had been quite well, relapsed.

There are now single *symmetrical* nodules under the skin above each elbow; very hard, rounded, movable, but adherent to skin. Above the elbows are numerous little scars of former sores. Her legs are still nearly well, but with a decided tendency to relapse. There are a few scabs on old scars, and a few subcutaneous indurations which are new. She seems to be threatened with rheumatism of left hip.

October 7, 1886.—I have not seen her since June. Since then she has used “sixty boxes” of the Ung. Hydr. for inunction; half a drachm every night. She has been very well all the time, “better in health than for years.” Not the least pyalism. Most of the sores on the legs are quite well (depressed scars with pigment at edges). A number of subcutaneous indurations still persist, and a number of fresh sores have formed. These are chiefly above the ankles, but there is one on the knee, and on the arms near the wrists are a group of them. On the arms they begin more distinctly in the skin itself, like little boils, whilst in the legs they begin under the skin. The eyes have been inflamed again.

November 2, 1886.—She is in excellent health, “excepting when I take the medicine.” There are still numerous sores on both legs, and a few on the forearms. They have undermined edges, and are very chronic in all their conditions, and but little inflamed. She has recently used an ointment of iodol., and taken bichloride with iodide. The fact that fresh places develop on the arms discourages us from the use of caustics.

November 30, 1886.—It is just a month since I saw her. She has had the mouth decidedly sore. She was obliged to interrupt the pills, which were Hydr. Subchlorid. gr. $\frac{1}{2}$ and Pulv. Opii. gr. $\frac{1}{8}$, quater die. There was pain and diarrhoea. The effect of the salivation was to dry up the sores on the legs, but they have not healed soundly. On the backs of wrists the sores have healed, leaving dusky livid scars. There is no doubt that all the sores on the legs have healed under the mercury.

Mrs. D— is quite well if she takes no medicine (iodide).

February 23, 1887.—I have not seen her since November 30, 1886. She then took home with her thirty half-drachm packets of “Lano-liniment mercuriale,” as dispensed by Martindale, and has used them. For some weeks none have been used. They produced no effect on the gums, and did not disagree in any way. The result has been that all the sores are quite healed. Some of the scars have horny scale-crusts on them, but they are sound and show no inflammation. The inunction has been left off for two or more weeks, and there has been no relapse. All the places on the arms are quite well. They have left dusky scars above the

elbows and along the backs of forearms. She is in excellent health, but complains that she feels nervous and does not walk so well as others. She walks, however, far better than a year ago. The local treatment has been an ointment of iodol and yellow oxide of mercury. She likes this ointment, and says that it has suited better than any other. As making it probable, however, that it has been the constitutional treatment, and not the local application, which has cured, it may be mentioned that the "little knots" under the skin of the arms have all melted away, and the ointment has not been used to them. It has been used only to the local sores.

August 23, 1887.—Has been in Switzerland, and walking much. Has been quite well for six months. Left off inunction in February. She left off all treatment before the sores were quite well, but they were rapidly improving, and the improvement continued. The cure is now complete. The legs are covered with scars, the margins of which are very deeply pigmented. There are also a number of little scars on the backs of arms just above the elbows, and one or two on backs of wrists. She is very well. Menstruation appears to be ceasing, but she feels well.

November 2, 1888.—She has had some fresh spots on the legs. She has a favourite ointment of mine, which she says always heals the sores, "but it takes a month." It contains iodol and yellow oxide of mercury. Her left leg is sound, with many dusky scars; the right has a few small ulcers. She looks very well. There are no spots on the arms. She has had little or no treatment for a year past, and has done very well.

July 19, 1892.—It is now eight years since I first saw Mrs. D——, and for four years she has been well. She is suffering from a slight relapse of ulceration on the legs; and pustular ophthalmia of the right eye is threatening (this afterwards developed into a severe attack).

October 13, 1892.—Her eye is now almost well, only two small pustules remain opposite each other and opposite the canthi. She looks very well. Her legs are quite well with the exception of one very small ulcer and one subcutaneous induration.

My last note concerning this remarkable case is as follows :

May 12, 1893.—She has a single, quiet pustule on the edge of the cornea. It has been present a month. She says that she had it last September much worse than now. It was then, as now, confined to the right eye. The legs are almost healed (under the mercurial ointment). She has a spot on the back of the left arm. Some spots which had threatened on the face have most of them disappeared. "The ointment is splendid."

The reader will, I trust, pardon the length of the above narrative, for the case is instructive not only in respect to the nature of the disease, but also as a lesson in therapeutics.

More or less under the influence of a mistaken diagnosis, specifics were, as we have recorded, used very freely and through very long periods. Repeatedly the gums were made sore. The patient was a somewhat fragile woman, who in early life had been threatened with phthisis. Yet no damage to her constitution resulted from this use of mercury during several years. She was always well whilst employing it, and she is now in excellent health and looking much younger than her years. These statements apply to the mercurial part of the treatment, for when the iodide of potassium was combined with it, loss of strength and flesh invariably followed. It is further to be stated that although specifics failed to cure the disease, and failed so completely that we may infer from their failure that the malady was not specific, yet mercury always did good. The general deduction may be fairly made that mercury does not injure the nutrition in scrofulous persons, but rather the reverse.

As to the pathological lessons of the case, attention may be asked to the following points:—

1. The patient was not improbably not only scrofulous but actually tuberculous.* She had been suspected of phthisis in early life, and brothers and sisters had died of that disease. It may, therefore, easily have been the fact that tubercle bacilli were extant in her frame ready to develop when opportunity offered. Yet during her long illness no symptoms of lung disease ever occurred, nor, with the exception of a slight relapse in an old focus in the neck, was there any tendency to enlargement of glands.

2. The case well illustrates the remarkable tendency to relapse which there is in this disease. These relapses were probably in part due to season and changing conditions of general health, but mainly to the existence of infective material left over in the skin in a quiescent state.

3. In passing we may note that so great repeatedly was the apparent benefit from mercury, that the original diagnosis seemed to be confirmed. A fallacy of course underlies all our

* I use the terms "scrofula" and "scrofulosis" for all that belongs to the state of tissues favouring the development of bacilli, but without their presence, and "tuberculosis" for what results from their actual presence.

inferences as to the effects of the remedies which were given internally, for at the same time we were using various local measures. Nothing is easier than to mistake for the effects of medicine what is really the consequence of some local application. In this instance I believe the cure was effected mainly by the ointment. This belief is strengthened by the results in several other of my cases. In the ointment, however, it was again mercury which proved curative.

4. The case shows beyond question that there is a tendency in the disease to affect the backs of the arms and even the wrists as well as the legs, though much less severely than the latter.

5. It also shows what is very important—a tendency for recurring attacks of pustular ophthalmia to be associated with the skin affection. The connection between pustular ophthalmia and scrofulosis has long been a puzzle for ophthalmological nosologists. For myself I have long held that there is undoubtedly a connection between the two, and that the occurrence of pustules (or phlyctenulæ) around the cornea is an indication of a scrofulous habit of body. Are they tubercular in the modern sense of the word? This may be doubted. As in the case before us, they are often recurrent, heal perfectly after a short duration (especially when treated by mercurial ointment), and but seldom lead to chronic ulceration.

CASE X.—*Furunculoid and ulcerating eruption on the legs, producing sores and scars which looked like those of Syphilis.*

The case of Mrs. B——, a lady whom I saw with Dr. P—— C——, was, like the preceding one, very puzzling. She had an eruption, placed almost symmetrically on the two legs, which began as painful tubercles which ulcerated and spread superficially. Some of the ulcers were as large as a child's palm, and had dusky tuberculated edges very like those of syphilis. Yet there was no history of syphilis, and the patches were symmetrical, and there were none on other parts of the body.

I saw her first at my own house in November, 1884, and then a second time on February 19, 1885. On the second occasion I was told that the ulcers had healed for a time but had now relapsed. There was now a tendency to spread up the thighs, a few inflamed tubercles, almost furuncular, being present on the outer sides of both thighs.

The history which I got was that Mrs. B—— had been married some years and had two children, the youngest eighteen months old. Both children were quite healthy. After her last confinement Mrs. B—— had measles, but they passed off well, and for ten months afterwards she had tolerably good health. It was in August of 1884 that the spots on the legs first showed themselves. She knew of no cause, and was not specially out of health at the time. The house was supposed to have had bad drains, but no one else suffered. Dr. C—— had tried iodides, arsenic, and mercury, but without result. Nor had iodoform or black wash seemed to suit locally. A suspicion crossed my mind that the so-called measles might possibly have been syphilis, but I was assured that it was quite transitory. There had never been any sore mouth or throat. There was no history of syphilis in her husband.

In December, 1885, I saw Mrs. B—— for a third time, and made the following note: She went to Brighton in the beginning of March, and remained there two months. She was worse at first, then better. My pill of Hydr. cum Cret. with iodide made her mouth very sore, and she left it off after two weeks. Since then she has taken my prescription with arsenic and small doses of opium. She has been improving all the time, and has been at times without a single open sore. She does not think that the salivation did her any special good. She was improving before, and has continued to do so since. For two months she has worn elastic stockings, and can now walk fairly. All the sores are healed excepting two little ones on the right leg. She has a copious eruption of lichen-acne on forehead and face, and she thinks that her complexion has become much darker. (Query from the arsenic.) Her general health is better, and she feels stronger. Still liable to neuralgic headaches in back of neck and head. Has taken for nearly nine months:—

Liq. Arsenic. m iij.

Tinct. Opii. Sed. m ij.

Tint. Nuc. Vom. m x.

Ter die ex aqua.

Thus it remains uncertain what has effected the improvement. She has used continuously a weak sulphate of zinc lotion, which has suited better than the ointments did. It may be that the small doses of opium long continued have done something. On the other hand, we must not forget the short but definite salivation.

The case differs from Mrs. D——'s (Case IX.), in that there is no affection of the skin above the elbows, although there have been a few below them, and that on the legs the disease is confined to their front aspects. The little subcutaneous tubers have been also less well-marked than in Mrs. D——. The characters of the ulcers produced and the scars left are exactly alike in the two.

The following case is one of the most characteristic and severe in my series. I have also the satisfaction of being

able to illustrate it by a good portrait, and to record a complete cure. Great interest had been taken in the case by several of my surgical friends, before the lad came under my care, and long periods of rest had been enforced. The cure was finally effected under free exercise in the open air. I believe that one observer thought that he had recognised tubercle bacilli in portions which had been cut for examination from the edges of the ulcers. I record the case, like the preceding one, in considerable detail, because it is necessary to secure the means of judging accurately as to the effect of different methods of treatment.

CASE XI.—*Multiple ulcers on both legs in a boy—No history of Syphilis—Intractability under treatment—Final cure by exercise, tonics, sea-air, and local applications of mercury. (See Plate CIII.)*

I first saw Master R. R.— on June 15, 1891. He was a healthy-looking boy, aged 12 years, and was brought to me on account of sores on the legs. These were first noticed at Easter, 1890, and then presented the appearance of “little red spots, looking as if a core had come out of a boil.” A month later he was under the care of Mr. E. O—, but in spite of treatment healing was slow. He was quite well for three weeks before Christmas, 1890. Most of the sores had healed in the summer, but all of them from time to time broke out afresh.

At the time of his first visit to me his legs were covered with scars, some of which were large and deep and involved the cellular tissue. A few spots had also occurred on the scalp, and one on the back of the upper arm. They had not been painful, and he would walk if he were allowed. His circulation was languid, and his feet liable to get cold in bed, though not in an extreme degree. Before the appearance of the first sore he had a broken chilblain on one toe.

I was told that on January 7, 1891, albumen had been detected in his urine, but I could find no trace of it at the time of his visit. Master R.— has three brothers and one sister, none of whom are ill, and amongst these he is fourth in order.

A week later (June 23), under treatment by iodoform ointment and liq. arsenicalis, the sores were all of them much better, and some were looking quite healthy. On July 23rd there was further improvement in the legs, and liq. arsenicalis was still taken twice a week.

I again saw the patient on September 16th, after he had spent seven weeks at Cromer, where his health had been excellent. Healing was slowly going on. Many of the sores had healed, and all looked healthy and superficial. There had been no spreading of the old ones, and no

fresh sores had appeared (with a single exception), although some had broken again after healing.

The treatment had been—Liq. arsenicalis twice a week and liq. hyd. perchlor. with cinchona. The ointment used had contained iodoform and yellow oxide of mercury. I advised a further stay of six weeks at the seaside.

On October 29, 1891, Master R—— again came to me. He had then been almost a year at the seaside (Folkestone), and had remained in good health. The ointment and internal remedies mentioned above had been continued, and in addition I had cauterised the sores once with acid-nitrate of mercury.

The legs were still covered with little ulcers, which discharged a good deal of glairy pus, and would easily bleed. They were much more superficial than formerly, and had shelving in place of undermined borders; but during the last six weeks none had healed, and three or four fresh ones had formed. The ulcers were sore after the dressings, but the skin between them was not in the least inflamed. The old scars were perfectly sound; they were not nummular but shelving, and not in the least pigmented. All the sores were florid, but smooth and destitute of granulations, and none remained above the knee. There was no roughness of the backs of the arms. The disease seemed to affect the cellular tissue rather than the skin.

On October 29th I changed the treatment, and ordered quinine and steel, and for one leg an ointment of bisulphuret of mercury, gr. ii. to the ounce, and for the other leg a lotion of nitrate of silver (gr. xx. ad ℥i.) to be applied on lint.

On December 10, 1891, I found that under the lotion some of the sores had healed quickly, but that they had broken out again soon afterwards. Those dressed with the ointment were for the most part healed. Almost all the sores were healed, and all looked healthy. The patient had been taking quinine and nux vomica internally. He had been living at home, and had been walking a good deal every day.

I may briefly summarise the subsequent notes of this case. Master R—— has remained under my care up to the present date (August, 1893). He has been improving the whole time, and it may be now recorded that his legs are quite well. He has been allowed to take exercise the whole time. The local applications have been varied. On several occasions I have cauterised sores which were especially unhealthy with the acid nitrate of mercury, and at one period he used at home as a daily application a strong solution of nitrate of silver. An ointment containing the bisulphate of mercury has, however, proved the most useful application, and it is under it

PLATE CIII.

BAZIN'S MALADY.—MULTIPLE ULCERS ON THE LEGS.

THE legs of Master R., Case XI., page 107, are here shown. It will be seen that there is slight general swelling, and that they are covered by scars and superficial ulcers. The latter are not well seen, being more or less covered by crust. The portrait was taken at a time when considerable improvement had been effected by treatment; but many of the ulcers still displayed, when the crusts were removed, irregular and somewhat undermined borders, and a surface destitute of granulations. The ankles and feet were wholly free, and so also, with very slight exceptions, were the parts above the knees. The portrait was taken about two years ago. At the present time all the sores are healed. Many of the scars are rather deep, and will be permanent.



that the cure has at length been brought about. The legs are left covered with scars, some of them of large size.

CASE XII.—*Multiple Ulcers on the legs of an adult woman with a fifteen years' history—Recurring attacks of sore mouth.*

I saw the lady who is the subject of the following notes on January 17, 1890. Her case is remarkable on account of the long persistence of the disease. There was not the slightest reason to suspect syphilis. I am sorry that I cannot state anything as regards the result of my treatment, as I saw the case only once. Miss B——, aged 30, of healthy family, consulted me in January, 1890, on account of ulcers of the legs. She had previously been under Dr. T. F—— and Dr. L——. Her legs were covered with white scars from ulcers which began when she was 15 years old; and some of them had become thick and like a papillary keloid. After scarlet fever she once had an eruption of boils. Six years before that her mouth had become sore; and the same occurred two years ago. On the latter occasion there were blisters on the inside of the cheeks and under the tongue. Caustics had been applied both to the legs and to the mouth. Four years previously she suffered from anæmia, and was "as white as possible," but had quite recovered.

CASE XIII.—*Cutaneous indurations in the legs—No actual Ulcers—Debility and feeble circulation.*

Rev. F. G. P——, an unmarried man, aged 33, of a dark sallow complexion, consulted me on January 19, 1891. He was of Irish family, but had been brought up in Canada. In boyhood he had been delicate, and at the age of 18 he had had typhoid fever; and since then had enjoyed better health. Formerly he had been engaged in a bank, but for the last two years he had been a clergyman. The ailment for which he came to me consisted of large indurations in the skin of his lower extremities. (They were somewhat like those in the case of Miss R——, but with the difference that they had not broken down.) They were as large as pennies, and appeared to begin beneath the skin, but had adhered to it. They appeared dusky, and had often been expected to break down and to suppurate, but this had never happened. They used to desquamate and then slowly melt away, a dusky patch, almost a scar, being left after resolution. Mr. P—— had had them for eighteen months, but at first only one had been present at a time. Since September, 1890, the same swellings had persisted. In addition to the lumps, he had some quite local varicosities of his veins. Behind and above the left popliteal space was a large knotted lump of this nature. The lower part of his abdomen was crossed by large veins, and close to his umbilicus were some lumps—apparently thrombosed varices. The right leg, which was not so bad

as the left, had not been affected till the previous September. Mr. P—— said that he was liable to spots in the mouth, which came and went, and were probably herpes. His gums formerly used to bleed, but this had ceased. There was a single sore near his anus, which had ulcerated and showed an ashy base. It was perhaps ulcerated herpes.

The patient complained of feeling languid and weak, but had not recently lost flesh. These symptoms suggested diabetes. His urine was yellow in colour, and had a specific gravity of 1025. He was not passing it in excess, but had done so formerly. He did not suffer from thirst; and his bowels were regular. He had never had jaundice, but thought his liver was out of order. He used to have sick headaches.

On January 24th the urine was again of a specific gravity of 1024. The medicine had caused griping pain.

On February 10th he looked better. The anal ulcer had healed; but the indurations were still present.

On March 20th I saw him again. He had been to Hastings for a month, and had felt very well. He had been taking a mixture containing arsenic and nux vomica. The subcutaneous lumps were still present, and were of a red colour. His legs were slightly œdematous. The lumps near the navel had disappeared, but the veins were still very large (superior epigastric).

CASE XIV.—*Gangrenous Ulcers on the legs of a robust adult man—Repeated relapses, with long intervals of health—No history of Syphilis—Insusceptibility to treatment—Cure by local use of Mercurial Ointment.*

The case of a man, named J——, seems worthy of record as an instance of ulcers on the leg, which had all the aspects of syphilis and yet were probably not of that nature. He was 49 years of age, a short, stout, florid man, who in his capacity as collector was constantly on his legs. He denied most positively having ever had syphilis, but admitted that all doctors had asked him the same question. He had been liable to ulcerations on his legs for many years; they had repeatedly got well, and then after a year or two others had formed. There had been an interval of complete soundness for five years before the attack for which he consulted me. Fifteen years ago my friend Mr. Cottle, after prolonged treatment, had cured the left leg, and it remained till this time quite sound, but with large scars. The type of ulceration was gangrenous, and at the same time infective. The inflammation spread subcutaneously from the first sore, producing a boggy spot at a little distance, which gave way and produced a fresh ulcer. [This was precisely the method of spreading which was observed in Miss ——'s case.] He was not liable to any other form of skin disease. When he came to me on September 2, 1891, he had on the front of his right leg a round ulcer with undermined edges, and in the middle a black slough of skin, still adherent, as

large as a shilling. The ulcer had been but little painful, and had been present only about five weeks. I examined the urine for sugar and found none. Both his testicles were in a state of chronic painless enlargement, but he said that they gave him no inconvenience and had been so for long. This condition induced me, in spite of his apparently clear and truthful denial of syphilis, to prescribe iodoform locally and the three iodides internally. After a fortnight under these measures the sore still remained, with a grey pultaceous base and slowly spreading edges. It was larger than before, and, though only in slight degree, was distinctly phagedænic. I now brushed it very freely over with the acid nitrate of mercury, and directed him to continue the treatment. On October 9th there was still some slough remaining from my caustic, and the edges of the sore were still not healthy. As the iodides and iodoform had now had a month's trial, I decided to change them, and gave him instead the solution of the bichloride of mercury in drachm doses, and an ointment containing half a drachm of calomel and two grains of bisulphuret of mercury to the ounce. A fortnight after this last prescription the change was most definite, the sore had contracted and showed healthy granulations in all parts. I may note, in passing, that during the early part of the treatment I had insisted on rest, but that during the last few weeks he had been walking about. He was so accustomed to constant exercise that he could not keep his circulation going without it, and remarked plaintively that his feet were always very cold on Sundays.

A fortnight after the last note I saw Mr. J—— again, and found the ulcer almost healed. There was, however, a certain amount of dusky oedema of skin at a little distance from it, which made him anxious lest it should form another sore. I have little doubt that the mercurial ointment was the real agent of cure, having often seen similar effects from it. I thought he had possibly been walking too much, and advised him to rest again.

A fortnight later still the leg was almost well. He was again walking about, and the ulcer not larger than a sixpence and quite healthy. Soon after this the sore healed soundly, and, so far as I know, it has remained well.

CASES XV. & XVI.—*Multiple Ulcers on the legs in association with Hydrops Articuli, and, probably, inheritance of both Gout and Scrofula.*

I may briefly refer to these two cases together, as they are closely similar. In each of them the patient, a lady of about 30 years of age, was the subject of a feeble circulation, with chronic arthritis and hydrops articulorum, in one of them many joints being affected, and in each there were multiple ulcers on the legs. The case of Mrs. B——, aged 29, I have already recorded in ARCHIVES, Vol. IV. p. 67. I find that I have

omitted in that report to say anything as to the condition of her legs. She had suffered from multiple ulcers on the legs, four or five at a time, for the last ten years, and counted as many as sixty separate scars and ulcers.

In a second case, that of Mrs. H——, aged 34, the patient was a lady of very fair complexion, who had suffered much from chilblains. She had lost one eye after an iridectomy for recurring iritis, and she had been for five years past the subject of hydrops articuli of her right knee, with considerable thickening of the synovial membrane. During the last nine months she had multiple ulcers on her left leg. They were similar in character to those described in my other cases. There did not appear any reason to suspect syphilis, and she had four healthy children.

In both of these cases I have little doubt that the joint affection was the result of a partnership of scrofula and gout. In neither case can I state the result of treatment with certainty, but I believe that in both the ulcers on the legs were cured by the local use of the bisulphuret ointment.

CASE XVII.—*Case of Bazin's Malady, illustrating the condition some years after cure.*

I have recently seen a remarkable case, illustrating the condition of things after cure of this disease. My patient was a surgeon, aged 31, who had suffered from ulcerated legs for three or four years, from the age of thirteen to eighteen. He presented a pair of legs covered with scars, which on the front aspects were very large, but small and insignificant on the calves. They extended from his ankles to his knees; and he had none elsewhere. The scars were all quite sound, and had been so for many years. They were dusky and pigmented at their edges. Any one, not acquainted with the facts as regards Bazin's Malady, would certainly have taken them for syphilitic. This was the patient's own diagnosis, and, as he had never exposed himself to any risk of contracting syphilis, he suspected that they were due to hereditary taint. Of this, however, there was not the slightest evidence. He was a man of feeble circulation, and although he had never had any chest delicacy himself, several of his relatives had died of tuberculosis. At the time that his legs were ulcerated he was living in Canada. His impression was that they were always better in cold weather and worse in summer. He had never suffered from any form of sun-eruption on his face or hands. He did not know what the

special measures were under which the cure had been brought about, but he remembered that various ointments had been applied. (A portrait and photograph have been preserved.)

CONCLUDING REMARKS.

With this case I conclude what, for the present, I have to record as to Bazin's malady. It would not be difficult, by searching through note-books, to multiply cases. I am no believer in new diseases, and although it is only during recent years that this group of cases has been recognised as presenting peculiar features and deserving of a special name, I do not doubt that many have in former times passed under observation and received only an imperfect diagnosis. The question still remains, Is it worth while, or desirable, to construct this new group and to trouble the profession with a new name? I feel no hesitation at all as to this. The cases are peculiar, and they ought to be recognised. Correct diagnosis will greatly help as to their treatment, as well as save us from the risk of causing unhappiness by blundering imputations. If, however, any observer should attempt to define closely the limits of "Bazin's malady," to say precisely which are examples of it and which not—to treat it, in fact, as if it were in itself a morbid entity, he will, I think, make a mistake. After all is said, these ulcerated legs are only a phase of the protean disease Scrofula. Not till we obtain clear conceptions of what we imply under that name shall we be able to assign "Bazin's malady" to its proper place. Nor do I make apology to any one for the name which I venture to propose. We must have some easily remembered and brief designation for colloquial and literary use. Bazin was an observer well worthy of any honour which such use of his name can confer. The term which he himself employed, although, so far as it went, accurately descriptive—"Erythème induré des scrofuleux"—is at once incomplete (omitting the ulceration), and too long for familiar use.

For the many who find it difficult, from want of leisure, to master the detailed descriptions of cases, the matter may be epitomised thus:—"Bazin's malady" is a name given to a

manifestation of scrofula occurring mostly in young women, in which multiple ulcers, the consequences of a subcutaneous and self-infective inflammation, occur on the legs, such ulcers being difficult of cure, prone to relapse, and presenting appearances very likely to be mistaken for syphilis.

ON JAUNDICE FROM SUPPRESSION.

THE phenomena of dry mouth—Xerostomia—have enabled us to appreciate the fact that it is possible for the functional activity of certain important glands to be entirely arrested under the influence of the nervous system. In most of the best marked examples of this malady which have been published, the condition has been permanent. The tongue, cheeks, lips, &c., remain absolutely dry under all conditions. It is a remarkable fact that the patient appears to suffer only inconvenience, there being no definite failure in health. Another noteworthy fact is that in almost all the cases hitherto recorded the patients have been women. We may, perhaps, derive some aid from what has been observed as regards this very remarkable symptom, in reference to the arrest of function of other glands, such, for instance, as the lachrymal glands, the glandular system of the stomach, the pancreas, liver, testes, and even the kidney. In all these it may be possible, under the influence of the nervous system, for permanent arrest of function to take place. In the instance of xerostomia, although brief arrests of function—the dry mouth of nervous excitement, for instance—are very common; and although in certain febrile diseases the tongue and mouth may be absolutely dry for weeks together, yet I do not know of any recorded example of what may be called “functional arrest” lasting a few weeks and then entirely passing off. As already stated, all the well-marked cases have been permanent or nearly so. In making this remark I am seeking for some parallel to what we know of functional arrests of the activity of the liver. In what is sometimes called, very inappropriately, “catarrhal jaundice,” it is not improbable that the essence of the disease is a complete temporary arrest

of secretion. The disease has nothing to do with catarrh, for its attacks are not produced by exposure to wet or cold. They are not liable as a rule to occur repeatedly, nor are they attended by any of the local signs of inflammation and local obstruction. That they are in some way connected with the nervous system is highly probable, and that they occur to those in whom there is an hereditary susceptibility may be taken as certain. In order to illustrate my topic I will briefly relate the particulars of a case. Although it is an example of what is very common, yet I think its citation may be useful in order that we may keep close to clinical facts.

A young lady of fair complexion and of nervous tendencies, but apparently in good health, was seized during the hottest of the recent hot weather with sickness and loss of appetite. She had no pain beyond a little sense of discomfort over the region of the liver, but she vomited everything that she swallowed, and could not retain even a few mouthfuls of water. Within twenty-four hours of the commencement of her sickness bile appeared in her urine, and on the next day her motions were the colour of pipe-clay. During the first three days no treatment beyond rest in bed was attempted. On the fourth day, as the eyes had become yellow and the vomiting still persisted, calomel in grain doses was given. From this date the sickness ceased, and the tongue, which had been much furred, cleaned; but the yellowness of the skin continued to increase for several days longer. There had not been at any time any material increase of temperature. The calomel was continued, in smaller doses and at longer intervals for about a week, and convalescence being then established the patient was allowed to get up. A week later, although still very yellow, she appeared to be quite well, and was as able to take long walks, &c., as before the illness.

In inquiring for a cause in the case which I have narrated, I was reminded by the patient's mother that I had once, some years ago, recognised jaundice in an elder sister, and that a younger sister was also liable to what were considered severe liver attacks, attended by sudden sickness, faintness, and sallow tint of skin. I was told also that a first cousin of

the patient, a girl about the same age living in New Zealand, had recently been laid up with an attack of jaundice.

We may take the above as a fair specimen of well-developed jaundice in connection with functional arrest. Bile was absent from the stools, and was present in the urine, and was abundantly deposited in the skin. The case, perhaps, does not quite prove that the liver had ceased to secrete, but it gives strong support to the suspicion that such was the case. There was not the slightest symptom of obstruction. Probably these cases of functional jaundice are only severe examples of the almost everyday occurrence of "liver attacks." Many patients are liable to attacks of biliousness during which the eyes become a little yellow, but in which the jaundice is never marked and the bile is never wholly absent from the motions nor obviously present in the urine. The difference is, however, probably only in degree. It is remarkable, however, that the amount of headache and general distress is not by any means always in ratio with the evidence of completeness of arrest of the liver function. Very severe sick-headaches may occur without demonstrable jaundice ; and what we may venture to call functional jaundice may be very well developed whilst the patient scarcely feels ill at all. As regards these differences, much probably depends on different degrees of nervous susceptibility in the patient. Many facts have been recently accumulated which suggest that we have entertained exaggerated notions as to the importance of the liver secretion in reference to health. On the one hand we have cases of biliary fistulæ, after operations, &c., in which the whole of the bile has been drained away externally, and never allowed to pass into the intestine, and in which yet the patient's process of assimilation did not appear to suffer ; and on the other we have cases of long continued mechanical obstruction without any rapid failure of health.

Attacks, more or less similar to the one which I have described, have, I believe, been very common during the recent hot summer. I have heard of them on all hands, and in those who were placed under most various circumstances. Two young men, brothers, total abstainers as regards stimulants, living in the same house, but engaged in different

occupations, have both of them been laid up at the same time with rather severe attacks of this form of jaundice. A medical man, whom I was treating for eczema, has also suffered from an attack. He had formerly lived in India, and might very possibly have some special proclivity to liver disorder. He referred his attack to "gastro-duodenal catarrh, which spread to the bile ducts and caused jaundice." As his attack was ushered in by diarrhoea, there is perhaps more plausibility in the method of development suggested than is usually the case. A common hypothesis, as regards what I would prefer to call functional jaundice, is that it is catarrhal, and that the catarrh begins in the duodenum, and in some way causes obstruction of the bile ducts. Plugging by mucus, for instance, is sometimes suggested. Not much that is plausible can probably be suggested in support of this hypothesis. Catarrhal inflammations are attended for the most part by excess of secretion; and not by obstructive swelling or inspissation of the discharges. It is very improbable that anything of the nature of mechanical obstruction by mucus is the cause of the attacks which we are considering. Nor do they obey the ordinary laws as regards catarrhal affections. In the latter it is usual for the patient to recognise the occasion on which he took cold. It is usual also for him to be liable to repeated attacks, at intervals, in connection with repeated exposure. Sensations of chilliness, and more or less tendency to shiver, are also the ordinary precursors of a catarrhal attack. These do not, however, usually occur in the beginning of jaundice, nor are those who have suffered from functional jaundice at all specially prone to have repeated attacks. I know many persons who enjoy good health, and do not consider themselves in any special degree "bilious," who have yet passed through single attacks of this affection. It is true there are a few who have had several attacks. A young medical friend tells me that he has had three, and that he is inclined to attribute them to anxiety or overwork.

I believe, however, that it is a matter of general experience that there are none who are liable to jaundice over and over again, with complete recovery between the attacks, after the

fashion in which so many are liable to severe catarrhal illnesses affecting the nose, throat, or chest. There are very many who are liable to recurring bilious attacks, during which probably more or less of liver suppression is present, but curiously this group of patients hardly ever get jaundice.

It would be of great value if some of the many intelligent observers engaged in family practice would carefully note their experience on these matters.

Respecting the pathological anatomy of this form of jaundice we are not likely to obtain many facts. Fatal cases do, however, occasionally come under notice. Death is usually preceded by cerebral symptoms. Even in the milder cases depression of spirits and general torpor of nervous functions are usually present. I find a report of a fatal case given by Dr. C. J. B. Aldis in some Clinical Reports published in 1835, which is of great value because it was followed by a post-mortem.* It appears to have differed only from the case which I have ventured to record as a good typical example of the malady, in the severity of the symptoms and the cerebral complication. The patient was a girl of sixteen, who was admitted into St. George's Hospital, having been jaundiced for a fortnight. She had been in very low spirits, crying nearly every day; and complaining that her head was very confused. Her mouth was parched and dry, and she had a nasty taste in her mouth. She was still very sick, had very severe headache, and was drowsy. She was deeply jaundiced, and stated that she saw everything of a yellow colour. On the evening of her admission her torpor passed into insensibility. The next day she was comatose, and in this condition died in the afternoon. Excepting

* We are not improbably liable here to the common fallacy that if a case is so severe as to end fatally, it is at once placed in another category. Acute yellow atrophy of the liver may, it is very possible, be the pathological anatomy of what is clinically functional arrest of liver action. If there be such a condition as arrest of function under nervous influence, analogous to xerostomia, nothing is more probable than that severe cases may now and then end in death, and that the affected organ may be found of reduced size and bile-stained.

The reader will find an excellent summary of present knowledge on this subject in Dr. Pye Smith's edition of "Fagge's Medicine." Several fatal cases from Dr. Bright and others are quoted.

intense bile-staining there was no disease of the viscera found at the post-mortem. The liver was soft, flaccid, and unusually small. Its substance was in parts stained with bile ; but there was no fluid bile in the ducts. The ductus communis was not obstructed, and was larger than usual. Dr. Aldis remarks, "There was nothing in the brain to account for the violent head-symptoms during life, which appear to have depended on the deranged state of the liver." He quotes from Mr. Twining's "Clinical Illustrations of Indian Disease" the following statement: "In some cases I have known robust patients die with symptoms of oppressed brain within thirty-six hours after the sudden appearance of intense jaundice ; for the accession of which last-named disease no cause could be assigned." That the coma in fatal cases of functional jaundice is due to blood-poisoning by the retained bile is made probable by what we know as to the mode of death in chronic jaundice. In a case, in which, a year or two ago, I was called in to do paracentesis in a case of long-continued jaundice with advanced cirrhosis of the liver, the mode of death was very peculiar. The patient, who was a robust man of about fifty-five, who had been a liberal champagne drinker, lay for three or four days in a condition of coma exactly resembling that of opium poisoning. It had set in rather suddenly, and some suspicion was entertained that a hypodermic injection of morphia had been administered by the nurse. Such, however, I feel sure, was not the case. The pupils, although small, were not extremely contracted, and to the last they reacted more or less on exposure. There was, as in opium-poisoning, a very remarkable retention of warmth in the extremities, although the pulse had almost ceased to be perceptible at the wrist.

The forms of liver disturbance, which are productive of the changes in the skin known as xanthoma, have scarcely received the amount of attention from physicians which they well deserve. They are probably by no means exactly the same in all cases, but we may probably suppose that in all they are due rather to functional inaction than to obstruction. It is not usual for any obstructive cause to be discovered at the autopsy in fatal cases, nor conversely do we observe anything

of the nature of xanthoma in cases of real obstruction. We seem, therefore, in the more ordinary forms of chronic xanthelasma to be dealing with long-continued functional disorder rather than with organic disease. That in the end organic disease, of the nature of cirrhosis, is in most cases developed is very probable. In some of these cases a very remarkable feature is the increased bulk of the liver and its proneness to temporary changes. In my papers on xanthelasma of the eyelids I have recorded several cases, in which the liver was liable to swell to such an extent as to become easily visible, filling a large part of the abdomen. In some of the most persistent cases of jaundice with xanthelasma, the tint of the skin becomes almost black, the patient still being able to persevere with his occupation. One or two illustrations of this will be found in the paper to which I have referred. That the form of liver disease, which leads to xanthelasma, is hereditary there can be no doubt, for the disease not unfrequently occurs in several relatives and in different generations.

In the forms of xanthelasma which are sometimes associated with diabetes—*Xanthelasma Diabeticorum*—although there is seldom any ordinary form of jaundice, there can yet be but little doubt that the liver is at fault. In these cases the patient will become covered very quickly with little papules or tubercles of a lemon-yellow tint, yet the skin itself is not bile-stained. Unlike the chronic and more ordinary forms of xanthelasma, these formations are capable of spontaneous disappearance, and usually vanish after a few months' duration. Although sugar is often found in the urine, this is not invariable. In one of the best characterised examples of the disease with which I am acquainted, the eruption being unusually plentiful, no sugar could ever be detected. The patient,* although not jaundiced, considered himself very bilious, and both he and one of his relatives were liable to extremely severe headaches, attended with sickness. There can be little doubt that some functional

* A good portrait of this man is preserved in the collection of the College of Surgeons and also in my own museum at Park Crescent. His case is published in *ARCHIVES*, Vol. I. p. 381.

disorder of the liver is the cause alike of the xanthelasma condition and of the sugar in the urine.

I must not dismiss the subject of functional disorders of the liver, leading as they do not infrequently to very severe derangements of general health and great diminution of aptitude for the pursuits of life, without saying a few words as to treatment. Certain principles in treatment are obvious to all. The avoidance of fatigue and worry, plenty of exercise and fresh air, and above all horse exercise, are recommendations which are easily given by the physician, but which it is often impossible for the patient adequately to follow out; nor will they, however well attended to, suffice, in cases in which the hereditary tendency is strong, to prevent the occurrence of attacks of liver disorder. We have, however, I believe, a drug at our command which, excepting under unusual conditions, will almost enable us to dispense with attention to these matters. If the patients, who are liable to liver disorders of the kind alluded to, will but take small doses of mercury for very long periods, they may, in ninety-nine cases out of a hundred, live like other people. A knowledge of this fact has come in connection with the modern use of small doses of mercury for the treatment of syphilis. In numberless cases patients, who had taken the drug for six months or a year, have declared themselves cured, not only of the syphilis, but of liver liabilities, which had previously very seriously interfered with the comfort of their lives. If mercury be given with the definite object of curing chronic liver disease and preventing sick headaches, &c., it should be prescribed in such doses that the patient does not feel it. It should neither purge nor salivate, and the patient, whilst under its influence, ought not as a rule to lose flesh. With these points in view the dose should of course be very small; but the course should be long-continued. The almost invariable result in properly selected cases will be, I believe, an improvement in the appetite, freedom from constipation and liability to headache, and a remarkable increase in nervous energy.

(See a postscript at p. 192.)

MELANOSIS FROM MOLES.

(*With Plate CIV.*)

ALTHOUGH the occurrence of melanosis in connection with congenital moles has long ago been described, yet most lamentable instances of delay in recognition, and consequently in treatment, still occur. Three such have come under my observation during the last year, and they were almost the counterparts of each other. The cause of error lies in the fact that the mole itself rarely makes any material growth. It always grows a little (and this should be the note of warning); but it still remains so insignificant that only the well-trained observer is likely to take alarm. In one of the three cases referred to, the surgeon consulted ligatured a little fungating growth from the mole, and it fell off and healed soundly, leaving, however, the black base (see Portrait). In another the surgeon applied caustic; and in a third a prescription for black wash was given, because the mole had ulcerated. In all three cases the treatment adopted caused the mole to heal, and apparently brought about a local cure; but in all, the temporary stage of activity, or inflammation, had sufficed to liberate the germs of the new growth, and had produced numerous secondary ones. In no case did the mole itself ever much exceed the dimensions of a fourpenny-bit. I have already recorded the particulars of the case which my plate illustrates; the other two I will now briefly describe.

CASE II.—*Ulceration of a Congenital Mole rapidly followed by general diffusion of Melanotic Sarcoma.*

A lady, aged 31, emaciated and in rapidly failing health, came under my observation when covered with growths of melanotic sarcoma. Both mammary glands were affected,

and on various parts of the trunk and limbs there were subcutaneous growths of considerable thickness. There were very few in the skin itself, and none that were absolutely black. Probably, however, many of them were pigmented, for, showing through the thin, partially transparent skin, they produced exactly the greenish tinge which our forefathers knew as chloroma. The axillary glands on the side nearest to the mole were somewhat enlarged, but there was no extensive infiltration of the lymphatics. The patient suffered severely from pain in her back and on various parts, and it appeared not improbable that both lungs and liver were already implicated. The whole of what I have described had developed within the last six months in connection with a mole on the skin of the abdomen scarcely larger than a pea. It was exactly like that shown in the portrait. The mole had been present from birth, but not until about a year ago did it give the slightest trouble. It then became sore, and grew somewhat. A surgeon, who was consulted, instead of cutting it out, contented himself with making several applications of caustic, which caused it to heal. Soon after it had healed, however, the secondary growths began to show themselves. It must be noted, as an exceptional feature in this case, that the mammary glands became infected, and that the growths were, almost without exception, under the skin, and not in it.

CASE III.—*Ulceration of a Congenital Mole, followed by general Melanosis.*

I saw Mrs. H—— May 14th, 1893. She was a married woman, aged 38, from near Nottingham. She showed me in the sole of her foot a little black sore about as big as a sixpence, which was obviously a melanotic mole. It caused her little or no inconvenience in walking, and although superficially ulcerated, showed no tendency to fungate. She told me that the mole had been present most of her life, and that about two years ago it had begun to grow and had become sore. Her own surgeon in the country wished to cut it out, but she obtained the advice of a London consultant, who ordered her to apply some lotion, which soon made it heal, and from that time to the present it had given her little or no

inconvenience. She subsequently sent me this unfortunately successful prescription, which was for black wash. The sore having healed, she entirely refused to accept the advice to have the spot excised. A few months later, however, the glands enlarged in the lower part of Scarpa's triangle. These were excised by Mr. W——, of Nottingham, and the wound healed well. When Mrs. H. came to me I could detect up the leg and along the inner part of the thigh, as high as the saphenous opening, a great number of subcutaneous nodules, and at some parts fusiform thickening of lymphatic trunks. Near to the scar of the operation for removal of glands there were three or four newly-enlarged glands as big as nuts. There were a few little shot-like growths visible in the skin itself along the line of the lymphatics of the leg. Most of the indurations were, however, distinctly subcutaneous. The case was obviously too far advanced for any operation to be of use. This opinion was confirmed a few weeks later by a letter from her medical attendant, stating that a growth had developed on one shoulder. The case precisely illustrates the remarks which I made in ARCHIVES, Vol. II., pp. 202 and 349, respecting the usual method of development of melanosis in moles, and I may refer my readers to page 202 for a representation of the condition in which probably the patient was in in the present case. Nothing is more remarkable than the quiet and apparently insignificant character retained throughout by the original growth, which yet infects with great rapidity the lymphatic system of the limb itself, and finally the patient's blood.

It is surely quite needless to point out that the only proper treatment for an inflamed or irritated mole is immediate and free excision. On no account should any temporising measures be permitted. The patient's only chance of safety consists in excision of the whole thickness of skin with a very wide margin. It is much to be desired that all members of the profession should have their minds fully alive to the features presented by these cases and the terrible results of loss of time. It is in the hope of impressing this lesson that I have thought it worth while to publish the portrait.

The following case may be quoted as one in which the local growth was large. It would appear that the tendency to local growth is in inverse proportion to that of infection of the system.

CASE IV.—*Melanosis taking its origin from a Mole—Large fungating growth.*

Mr. O——, aged 51, was sent to me on June 9, 1892. Ten months previously a mole, which he had long had on his abdomen, commenced to grow, and at the time of his visit there was a large fungating mass in the middle of the abdomen, with little shot-like growths of melanosis near it, and others which were not coloured. There were present many little moles of various size and character. The glands in both groins were hard, and the lymphatics down the thighs were tender.

Dr. E—— subsequently reported to me that the cancer grew rapidly, and became a very large, offensive mass. The poor fellow, under his sufferings, became the subject of delusions, and, being violent and suicidal, had to be placed in an asylum. He was relieved by death on December 12th.

CASE V.—*Large Local Melanotic Growth from a Mole.*

I may just mention a fifth case, which differs only from the three preceding in that there is as yet no proof of constitutional infection. In it I excised from the back of a man, aged about 60, a very large elliptical portion of skin which was involved in melanosis from a growing mole. The mole had grown from the size of a sixpence to that of a child's hand, but there was no proof of any infection of the system. The wound has for the present healed; but, as the mole had entered upon its sarcomatous stage at least a year before the operation was done, I am much afraid that before long I shall hear of recurrence in the viscera.

PLATE CIV.

MELANOSIS IN A MOLE, WITH SECONDARY GLAND DISEASE.

On the right side of the abdomen is seen a little black patch. At the site of this patch there had been a congenital mole. During the year preceding the sketch, this mole had grown and produced a little, fungating excrescence, which a surgeon removed by ligature. The wound healed, but the base of the sore remained black, and shortly afterwards the glands below the axilla began to enlarge. When I was consulted, not only was there a mass in the armpit, but a long chain of indurated glands extended up the neck, under the sterno-mastoid. Any further operation was clearly impracticable. The man died with an enormous gland mass, and with indications of internal visceral disease, within about a year of the time when his mole first began to fungate. The case affords the clearest possible proof of the necessity for free and early excision of all moles which show any tendency to take on growth.



THE TREATMENT OF STRANGULATED HERNIA.

THE results of operations for strangulated hernia, at the present day, present some questions which ought to receive our most careful consideration. It would appear, not only that the advance in what is called abdominal surgery has in this department achieved no triumphs, but that our art has positively gone backward. I will endeavour to state as fairly as I can the changes which have taken place in opinions and results within my own experience. In the first place we have to note, during the last half-century, the growth of a very decided distrust of attempts at reduction by taxis, and a preference for immediate operations. This is very emphatic indeed in the teaching of our schools. A student is now scarcely instructed in the details of the taxis, and is warned that if he attempts it at all it must be in the very gentlest manner, and only for a very short time. During the later years of my examinership at the College of Surgeons, I was often amused to see that a student would treat a question as to the details of taxis as if he thought it were a sort of trap for him, and would reply at once that he would use it only for a minute or two, as gently as possible, and then proceed to the operation. Nor does this timidity, I believe, in the least exaggerate the precepts of some of our leading surgeons. I have been assured by several, whom I have asked as to their proportion of successes by taxis, that they scarcely ever attempt it, but prefer to operate at once. In this we have, indeed, a most remarkable change from the opinions which were prevalent in former days. When I was a student in the city of York, there was a surgeon living there who had the repute of being able to reduce all hernias. He was a man of short stature, powerful frame, and very strong hands. He

was not popular in the city, and especially not so amongst the profession; but his boast was, and I believe it was to a large extent supported by facts, that, when a patient had a rupture which his medical attendant could not get back, there was generally a demand that Mr. Hopps should be called in. There was a tradition that he used sometimes to kneel upon them; but this, I believe, was scandal. That he was remarkably successful I have no doubt whatever. In those days we did not know that death might occur after reduction by taxis, and our belief was that a success with the fingers was a triumph without a drawback, saving the patient from a very perilous operation. When, on leaving York, I came up to St. Bartholomew's Hospital, I was there taught by Mr. Wormald that it was practicable to succeed by the taxis in a majority of cases. Mr. Wormald was a man, like my York teacher, of good muscular development, and with large powerful hands. He told me, what I had in part learnt before, that it was exceedingly important in the different forms of hernia to keep accurately in mind the direction in which the reduction had to take place, to use the left hand for steadying the neck of the sac and the right for compression. I was taught also even to try to make the neck of the sac slip downwards at the same time that I compressed the hernia. In particular Mr. Wormald insisted that all *inguinal* herniæ might be reduced by taxis; and I well remember his chagrin when, on one such, he was unable to succeed and was obliged to operate. I believe it was the first case in which he had used the knife for inguinal hernia, and he had then been assistant-surgeon to St. Bartholomew's Hospital for some years. There was a joke against Mr. Stanley, another highly valued teacher of mine, that he had refused to let Mr. Wormald examine a hernia, on which he was about to operate, being afraid that it might be reduced. The line of practice which reached its acme in such men as Mr. Hopps in York and Mr. Wormald in London was by no means peculiar to them, but was attempted, though with less success and in some instances with less zeal, by all the surgeons of that day. Every one reduced by the taxis as many as he could, and a great variety of what were called "adjuvants to the taxis" were in common use. Amongst

these, the hot bath, pushed to faintness, and the application of ice to the tumour were the chief; but alterations in the position of the patient's body and even shaking the body in the inverted position were occasionally resorted to. When chloroform came into general use, and it was found that by its aid not only might the patient be saved all pain during the manipulations, but that the abdominal muscles might be placed in a condition of absolute inaction, great hopes were entertained that the taxis would prove more frequently successful than ever. The medical journals of the day teemed with narratives of successful reductions under chloroform. At a later period, the use of the ether spray over the tumour itself, as an improvement on the ice-bag, received the warm commendations of many. I believe that there are some surgeons of the present day who would shudder at the bare idea of putting ice on a hernial tumour.

About the year 1840, Mr. Luke took up warmly the advocacy of Petit's operation, which he regarded as a sort of half-way between the taxis and a complete herniotomy. As is well known, it avoided opening the peritoneum. All the surgeons at the London Hospital and many at others followed Mr. Luke's practice. It was believed that here again a very important advance had been made, and in Druitt's "*Vade Mecum of Surgery*" (1847) I find it stated that Mr. Luke's ratio of fatality after hernia operations by the new method had been reduced to two in forty. It is right that I should add that I cannot help feeling some doubt as to whether this statistical statement is well-founded; but I do not recollect ever to have seen it contradicted. The surgeons of St. George's Hospital from the first, and almost in a phalanx, refused to follow the fashion as regards not opening the sac, and they were able at a subsequent period to show by a comparison of statistics with those of the London Hospital that the gross results of the two methods did not differ much. It is to be remembered that these statistics were obtained at a time when attempts at taxis were persevered in far more than they are at present, and when consequently only a residuum of the worst cases were submitted to the knife.

I may perhaps be pardoned if I now state my general im-

pressions as to my personal practice. The London Hospital has probably for long had the largest practice in strangulated hernia of any institution in London, perhaps in the world. It is in the centre of a densely populated district inhabited by working people. St. Bartholomew's and Guy's probably come very near to it, and at these three institutions operations for strangulated hernia average from twenty to thirty a year, or about one every fortnight. When I was elected on the staff of the London Hospital in the year 1859, I was, as may be supposed from what I have said as to my teachers, although very fond of operating, a zealous manipulator, and one who took pride in success by the taxis. Especially I used to take the utmost pains with inguinal herniæ, and I may here say that I have never, either in my own practice or in that of any other surgeon, known of any case of death after a satisfactory reduction by taxis of an inguinal hernia. From this statement, of course I except all cases of incomplete reductions, cases in which the bowel is pushed between the layers of muscles and cases of *reductio en masse*. In all these the symptoms persist and an immediate operation ought to follow. What I mean is that I have never known a case, in which the intestine had slipped fully and freely into the peritoneal cavity, do otherwise than well. I cannot make this statement as regards femoral hernia, for I have known three or four cases in which, after complete reduction, the patient yet died of peritonitis.

I was on active duty, as one of the staff of the London Hospital, for twenty-four years, and, during most of this period, from a fourth to a third of the hernia cases admitted into the wards would fall to my share. During part of this time one of my colleagues, who early adopted the principle of preference for operation over taxis, used to operate, I believe, on nearly twice as many cases as I did. I was once told that my house-surgeons said that it was no use sending for me to a hernia operation, because I always spoilt the case; and I have little doubt that this belief induced them to take much more pains with the taxis before sending for me than would otherwise have been the case. My rule was always to try the taxis patiently, if there were no indications

that the bowel was already in a bad condition. If either the general state of the patient or the local condition of the tumour seemed to imply the latter, then I always operated at once and always opened the sac. If the case seemed one to justify an attempt at taxis, then I always held that it was one in which, if practicable, it was best not to open the sac. It seemed clear that in all cases in which, on inspection of the gut, it was thought well to return it into the abdominal cavity, it would have been still better to have reduced it without exposure. Only the cases in which the surgeon deems it his duty to leave the gut in the sac (or to excise it, according to modern practice) are those in which success by taxis would not have been an advantage. As regards the amount of force in applying the taxis, I can only say that I used all that my hands possessed, and that I often wished that they were stronger and did not tire so soon. In inguinal herniæ I have, when my hands were tired, asked one of my colleagues or my house-surgeon, or even both, to take a turn; and more than once I recollect Mr. Louis Little or Mr. Waren Tay having succeeded after I had failed to do so. One remarkable case is imprinted on my memory of an inguinal hernia in an adult man, in whom, under an anæsthetic and in the operating theatre, Mr. Tay and myself had tired our hands in repeated attempts; and as a last resource, just before proceeding to the knife, I asked my house-surgeon to do his best, and he succeeded.

I may here say that I have never been guilty of delay in operating for strangulated hernia, unless the time taken up by the taxis be considered such. Only in exceptional cases, in which the strangulation was ill marked, have I ventured on any prolonged use of ice. The hot bath had usually, as a matter of routine, been tried by the house-surgeon before I saw the patient. As years went on I felt more and more confidence in anæsthetics as superseding all other adjuvants of the taxis. Almost invariably the patient's assent to an operation was obtained before the anæsthetic was used, and, if the hands failed, the knife was forthwith employed. There is a great difference between patient efforts at the taxis and delayal of the operation. I am very in-

credulous as regards the harm done by careful though very forcible manipulation. The bowel is as a rule well protected, not only by fluid in the sac, but by a layer of fat over it; and it is not possible by any ordinary force to damage it by bruising. The appearances which are so frequently attributed to bruising, are really, I hold, the consequences of the stricture. I have seen the soft parts ecchymosed as a result of bruising, but I never saw anything in the gut itself which I thought attributable to the manipulations. Of such an occurrence as rupture of the intestine I have had no experience whatever. In a case in which I operated only a few weeks ago, there was a considerable extravasation of blood external to the sac, which looked formidable enough when the incision was made, and which was, I have no doubt, due to forcible manipulation. The patient was elderly, with diseased vessels. I did not open the sac, and so cannot report as to the state of its contents, but the ecchymosed parts healed without a trace of suppuration, and there was no drawback to the patient's rapid recovery.

It is not in my power to give anything approaching to full statistics of my ratio of success by taxis and herniotomy respectively as compared with that of my colleagues; nor would it be graceful to attempt it. I may say, however, that several of my colleagues—Mr. Luke, Mr. John Adams, Mr. Curling, Mr. Nathaniel Ward, and others—adopted the same rules as regards patient trial of the taxis, and the use of all suitable adjuvants, that I did. I may, however, just mention that for the year 1875 the Registrar credits me with having had no operations for hernia at all, although my average share ought to have been eight.

It may be suitable, perhaps, that I should record my experience as regards the supposed difference between hernia cases seen in private and those in hospital. It is customary to say that the hospital cases are a much less hopeful series than those seen in private. My impression is that the reverse is the truth. When I lived in Finsbury Circus I had a large experience of hernia operations in private at the East End of London. It was the day of small fees and many patients, and it ended when I changed my resi-

dence. When a case of strangulated hernia occurs to a poor person, in many instances the patient goes straight to the hospital. In many others the surgeon who is first consulted does not choose to accept any responsibility in the case, and immediately sends it there. Amongst patients able to pay for advice, it is well known that if a consultant is called in a fee will have to be paid, and thus but too often the family practitioner is encouraged to persevere unaided, until the symptoms become so severe as obviously to admit of no delay. The average duration of strangulation in the cases to which I have been called in private, has I believe been much longer than in hospital cases. I have met with gangrenous intestine more frequently in private than at the hospital, and the opportunities for really early operation occur I believe far more frequently at hospitals than they do to consulting surgeons in private. This impression is confirmed by what I observe stated as to the duration of strangulation in some of our hospital reports. Thus in those of St. George's I find it repeatedly recorded that the operation was done within six hours of the time of strangulation. I do not think that I ever in my life saw a case in private practice in which the duration had been so short.

These remarks obviously apply to cases as seen by consultants, and not to those under family practitioners. In private the latter intervene and often succeed; whilst in the cases to which we are called in the hospital very often they have had no share, and the patient is under the care of the operator almost from the beginning.

(To be continued.)

MUSEUM NOTES.

THE following notes concern specimens which have claimed my interest at different museums during the present summer. They are chiefly from the Musée Dupuytren at Paris, and where I have used the initials M. D. it is this collection which is intended.

An Endemic Pigment Disease (Gomez' malady).

In the Musée Dupuytren are ten oil-paintings illustrating different stages and forms of a pigmentary disease of the skin called Carather or "Taches endemiques des Cordilleras." One is the espèce grise and another the espèce bleue.

Reference is made to a Thesis by M. Josne Gomez, published in 1879. I did my best, but without success, to obtain this essay. The portraits are of patients whose cases are there published.

All the portraits are those of men. They show deposit of pigment in large very ill-defined blotches on face and limbs. In some absorption has been in progress and leucodermic areas have been left.

I am not aware that this disease has as yet been noticed in English literature, and it therefore seems worth while to draw attention to it. So far as an inspection of the portraits themselves will go, a suspicion might be entertained that the disease is an example of what is known both in Vienna and in Paris as Leucoderma Syphiliticum, a pigmentary form of secondary syphilis. There is nothing improbable in the supposition that in tropical climates the tendency to pigmentation in a syphilitic exanthem may be much more likely to occur than it is with us. In England we but rarely see anything approaching the characters of leucoderma in association with

syphilis. I must throw out this suggestion with much diffidence, since I have not read the author's description of his portraits. The thanks of the profession are due to him for procuring, probably under circumstances of difficulty, such good pictorial illustrations.

The Diffuse Lipoma of Beer-drinkers.

I have never seen in Paris, either in the streets or in hospitals, any examples of the diffuse lipoma of the neck, &c. In the M. D., however, there are two models representing this disease. One of them shows the largest masses which I have ever seen. The man's head projects out of a mountain of fat. It beats utterly the portrait which Mr. Swainson did for me and which was, at the time, the largest I had ever seen. This model is No. 87, but no one seeking it can miss it. By its side No. 87A, which represents the same disease, might be taken for a normal condition.

Osteitis Deformans.

No. 333, in the D. M. is a collection of bones showing "Hyperostose général de la tête, de la column vertebrale, des côtes, du sacrum et de l'os iliac. Homme de 70 ans." M. Rullier.

The bones are splendid examples of Osteitis deformans.

No. 375. Hypertrophic thickening of the frontal bone, &c., in a child. Anterior fontanelle still open. This preparation offers a very remarkable simulation of Osteitis deformans from a child. It is labelled "Hyperostosis des os de la voute du crâne chez un enfant de 18 mois." I took it at first sight for the top of an adult skull with osteitis deformans, but on observing more carefully I saw that only the bones of the anterior half are involved and that there is a hole through it at the position of the anterior fontanelle. The thickness of the frontal bone where cut can scarcely be less than half an inch. There are no traces of inflammation.

Specimens of Rickets.

The specimens of rickets in the Dupuytren Museum are very numerous and good. They show over and over again that

in the form of the disease in which the bones bend there is no arrest of the growth in length nor any evidence of overgrowth at the epiphyses. There are long, slender bones bent into most various shapes. Thus it is certain that although rickety persons may lose in stature they do not do so from want of growth of the limb-bones. It is further certain that there is a form of intra-uterine rickets in which the bones bend but show no thickening at any part nor any defect as to length. Specimens 513 and 514 ought to be photographed side by side. Both show the skeleton of a fœtus. In one the bones are shapely and long, but those of the lower limbs much bent, whilst in the other all the conditions of the thick-boned, short-limbed dwarf, as seen in the Norwich skeleton are reproduced. It is clear, then, that, if the latter be rickets at all, there are two forms of that disease during intra-uterine life, one attended by arrest of growth of long bones, and the other not. These two specimens are described as follows: 513, "*Squelette de fœtus dont les membres inferieurs sont atteints de rachitisme congenitale. M. Skellage.*" In this the bones of the lower extremities, of good length and not thickened, are much bent in diverse directions, probably by intra-uterine pressure. Owing to loss of height from the bending of the femora, the fingers touch the knees. None of the epiphyses are altered in shape.

514 is a fac-simile of the Norwich dwarf, making allowance for age. All the long bones are very short and thick. They are not in the least bent, but yet the finger-tips scarcely touch the iliac crests. The epiphysal ends are very large. The specimen is somewhat erroneously described as "*Enfant a terme dont les os presentent les courbures rachitiques avec une hypertrophie des os qui peut être considerée commes une re-ossification.*" There is not the slightest trace of courbures; indeed they are too short to be curved.

514b is figured in Hoel's Atlas to Catalogue as a short-limbed dwarf. "*Fœtus dont les os presentent une ossification premature avec des courbures anormales.*"

514c (not dissected) is another specimen of a short-limbed fœtus, and it, with 514a, might be claimed as intra-uterine rickets. Both are described as such. In neither, however,

is there any bending. The conditions are arrest of growth in length with great general thickening. In both cases the finger-tips just touch the iliac crests. 514A is partially dissected and the state of the foetus is represented by a plaster cast.

The Skeletons of Dwarfs.

331B is the skeleton of an adult dwarf. It is the counterpart of the Norwich skeleton, but has in addition an extreme lateral curvature of spine which very greatly reduces the height of the trunk. It is labelled "Squelette atteint de deviations rachitique, les membres superieurs et inferieurs sont frappe d'arret de developpement." Thus it will be observed that both "rickets" and "arrest of development" are assigned as causes. The question is Which? I cannot discover any trace of rickets, unless the enlarged epiphyses be assumed to be such. This would, however, be to take for granted what is not proven. Undoubtedly all these short-limbed dwarfs show it, and disease of the epiphyses was probably a cause of the arrest of growth. Has this epiphysal abnormality, however, anything in common with ordinary rickets? In this skeleton all the long bones are very short and their ends clumsy and thick. Their shafts are well rounded and smooth, especially those of the bones of the lower limbs. The humeri are thick and show strong ridges like those of the Norwich specimen. Not a single bone shows any curve, nor are the ribs or the pelvic bones altered. The pelvis is small but broad (a woman?). The altered shape of the femoral necks twists the bones so that the knees look outwards and the feet have their soles towards each other. The feet have very high arches and the heels are drawn up—they were probably "clubbed." The sternal ends of the clavicles appear to be somewhat sloped but not so much as in the Norwich specimen. If the spine were straight the tips of the fingers would only just touch the iliac crests. The head and teeth are well formed.

There are short-limbed dwarfs in which the shortness of limb is extreme and is due to entire absence of some of the bones. Without feeling at all certain on the subject, I yet do not see

any definite reason for declining to recognise these as resulting from a yet more severe failure of the same kind as that which causes shortness of the long bones. It is precisely the same bones which are defective. In both groups of cases the hands and feet are fairly well developed, whilst the femur, tibia and fibula, the humerus, radius and ulna are the bones which are shortened in the one group and almost wholly absent in the other.

Illustrations of Absence of the Principal Bones of the Limbs.

The best examples of the partial absence of the long limb-bones which I know of are to be found in the Musée Dupuytren. 29 and 30 in this museum probably belong to the same man, although it is not so stated. They are almost exactly alike. 30 (the cast) is described as "Modele en plâtre du nomme Pepin, dont le tronc est bien conformé, mais les membres thoraciques et abdominaux sauf les mains et les pieds, ne sont pas développés." 29 (the skeleton) is described as "Squelette d'un homme mort à Bicêtre, à l'âge de 62. Les membres thoraciques et abdominaux sont imparfaits."

I will describe the skeleton, and may say that the plaster cast presents nothing inconsistent with the supposition that it represents the same individual during life.

The hands are perfect, and so too are the feet with the exception that the arches are very high and the insteps correspondingly short.

To each foot is attached a short portion of the tibia without any trace of fibula. The tibia ends in an obtuse point about three inches above the ankle, and of the bones of the knee or shaft of femur there is no trace until we come to the base of the lesser trochanter; above this level the neck, great trochanter and head of femur, are of natural form and size. The femur ends abruptly, as if it had been broken transversely and the lines of fracture rounded off. There is no deformation of the femoral epiphysis. The limbs being shortened the feet are placed across what should have been the top of the thigh and the fragment of the tibia passes in front of the neck of femur and almost touches the lower anterior spine of ilium. On the right side it appears to have

actually touched, for a flattened surface is seen, due probably to its attrition. On the left there is a connecting ligament.

The hands, as I have said, are well formed and of normal size, and they possess, so far as I could see, the proper number of carpal bones, but of radius ulna or humerus there is no trace. The shoulder bones are well-formed, coracoid, acromion, and clavicle, but the glenoid cavity on each side is filled and presents instead of a hollow a rounded projection of bone.

The ribs, thorax, vertebræ, and pelvis are well formed, but the bones of the latter are small and light for a man (partial disuse).

No 28 is a foetus which almost repeats the extraordinary conditions of 29 and 30. It has well-formed hands and feet, but they are attached, like fins, to the trunk without intervening bones. The feet are turned towards each other so that their soles touch. It is described as "Fœtus d'environ 7 mois qui présente un grand nombre des plis verticaux de la peau, qui est en excès." The skin hangs loosely like a bed-gown on the short, almost limbless, foetus. Another example of the same condition is presented in No. 31, with the important difference, however, that only the upper extremities are affected. In this specimen the hands rest within an inch or two of the shoulder joints. The hands themselves are small but well formed. It is a full-grown foetus. The lower limbs present no peculiarity. It is described as "Fœtus phocomele, les membres thoraciques manquent et les mains paroissent s'interer au tronc." An incision has been made into the soft parts in front of one shoulder, and so far as can be distinguished the pectoral muscles are present. In the plaster cast, 29, they appear to be absent.

We have in specimen 45 an example of abortive limbs in a puppy. The four limbs hang like small fins on a dumpy, rounded body. They are defectively developed. The head and face are much malformed and the brain probably absent. It is therefore an example of failure of development of the limbs in association with extreme defect of the nervous centres. It is not dissected.

(To be continued.)

ECZEMA AND HOT WEATHER.

THE hot weather of the past summer has been productive of a great many cases of the diffuse eczema which so often affects the aged. The epidemics which occurred in the Workhouses, to which I have repeatedly referred, have helped us to a clearer recognition of the influence of summer in producing these attacks. As a rule, in the sporadic cases, the attack is not absolutely a novelty to the patient. Almost always there is the history that there has been for long a quiet, chronic patch of eczema on the leg, behind the ear, on the scalp or somewhere, which, under the influence of the summer weather, has been exacerbated and shown a tendency to spread over the whole surface. I do not think that much can be said as to the influence of gouty conditions, or of diet, in exciting these outbreaks of dermatitis. They happen to all sorts of people, and the fact that epidemics have occurred in workhouses is in itself an almost conclusive answer to the suggestion that they are connected with gout. My impression is that heat, and the perspiration that attends it, are the main factors. It is quite clear that in some way a self-infective material is generated, which has the power of causing the dermatitis that attends its evolution to spread, more or less rapidly and widely, from its focus of origin. I have already asked attention to the features in which this dermatitis resembles a mild form of erysipelas, and have ventured to advance the hypothesis that there are cases in which it is really a hybrid between erysipelas and eczema. I do not purpose to trouble my readers on the present occasion with any further discussion on these points; but it may be of interest to narrate briefly a few cases which illustrate them. The first which I shall mention is the last

that I have seen, an old gentleman, who has come under my observation on the morning of my writing this. He bore the most emphatic testimony to the influence of hot weather in aggravating his eczema.

Pruriginous Eczema of twenty years' duration—Always worse in summer.

Mr. A——, aged 68, a stout and very healthy farmer, “an abstainer, but not pledged,” has been the subject of eczema for twenty years or more. By his own avowal he has been a good scratcher for at least thirty. His father, he says, suffered in the same way. He is, at the present time, covered with pruriginous papules and large ill-defined patches of eczema. The eczema is best developed on the nape of his neck and his scalp; but it is well characterised on other parts also. Mr. A——’s testimony is that his skin is always very irritable in summer weather, and that it gets almost well in the cold of winter. Although he has suffered so long, he has never until the present occasion sought medical advice. He excuses this negligence by saying that his father never got cured, but there is no doubt that, in consequence of the prolonged summer, his condition is now far worse than ever before. It now quite destroys his rest at night. I prescribed for him a tar wash, a tar ointment and a mixture containing tartar emetic.

This case as nearly approached the type known as “Hebra’s prurigo” as any which I have seen for years. It was, however, distinctly a lichen-eczema, and instead of beginning in childhood it did not commence until middle life.

It will be seen that this case differs somewhat from those to which I have alluded above, in that there has been no sudden outbreak of an infective inflammation of the skin. There has been nothing at all approaching to erysipelatous swelling in the case. Two or three of those which I am about to relate are examples of very sudden and severe outbreaks, attended with vesication and great œdema of the skin. These cases are too acute to be attended by prurigo. It may be remarked that in proportion to the acuteness and suddenness of their development is usually the ease with which

they are arrested. The reader will note that in some of these cases the patient had experienced a precisely similar attack some years before. The question arises, in reference to this class of cases, as to whether there is any truly catarrhal element of causation in them.

Liability to attacks of an Acute Vesicating Eruption in the face and hands—Senility—Influence of sunny weather.

Mrs. G—— consulted me a second time for a very severe relapse, in April, 1893. She told me that, during the five years which had intervened, she had experienced no serious attack. On several occasions, and chiefly, she thought, in spring weather, she had been threatened; but had always resorted to the remedies which I had prescribed, and nothing had ever developed. At Christmas, 1892, however, her face was again attacked, and, although she managed to ward it off for a time, at Easter, during days of hot sun and east wind, it blazed up with great severity. Her face swelled so that it closed her eyelids, and, in spite of all treatment, the attack persisted, until a month later she came up to town and called on me. She said that she had no doubt that the attack had been produced by working in the garden during the spring weather. Her face and neck were still covered with scaly desquamation, and the skin was swollen and congested. The prolabia were cracked, and there were fissures at the corners of the mouth. The hands also were in a condition of diffuse congestion with desquamation. The attack had been strictly limited to the face, neck, and hands. She had been feverish and ill during its height, but had regained her usual health when I saw her. She was now 74 years of age. Her case was in all respects exactly like that of the boy Bennett (see page 144).

Liability to attacks of a Vesicating Eruption on the face and hands.

A Mrs. D——, aged 52, who was sent to me, April 17, 1893, by Mr. Bevan, of the Commercial Road, affords a very close parallel to the preceding (Mrs. G——) and other cases. She came to me with her face and neck red and desquama-

ting. Her hands were in a similar condition, though less severely affected. She said that the attack had commenced six weeks before, and that it had begun on her neck, apparently from the irritation of her frilled collar. It had been very severe, and for a time had closed her eyelids. After it had involved the whole of her face, the hands were attacked. It had not extended lower on her chest than her clavicles, nor on her forearms much higher than her wrists. It will be seen that this attack began, like Mrs. G——'s, during hot spring weather, and that the two commenced almost at the same time. In Mrs. D——, however, there was no history of any special exposure to sun. In connection with this matter, however, the following fact is of great interest. Mrs. D—— told me that she had suffered twelve years before from a very severe attack of eczematous dermatitis, which was confined to her hands. She had been out all day in a boat in the hot sun, and, to use her own expression, on the following day her fingers were covered with little blisters, "as if I had tipped a kettle of boiling water over my hands." On this occasion her face did not suffer, but the inflammation of her hands lasted six weeks. She never afterwards had a severe attack until the present one, but on several occasions had had slight threatenings.

Acute attacks of a Vesicating and Bullous Eruption on the face and hands in an elderly woman.

I had seen this lady in consultation with Dr. S—— for a very severe outbreak of erysipelas-eczema on her face and forearms about three years before our recent consultation. I then prescribed an antimonial mixture and lead lotion. I saw her but once. The second consultation was for an attack of precisely the same kind, but yet more severe. Her forearms were covered, not only with vesicles, but with large vesications, as if they had been scalded. These vesications were totally different from the bullæ of pemphigus, being produced by the coalition of adjacent vesicles, and being very irregular in form. Mrs. M—— told me that what I had prescribed on the former occasion had cured her quickly, and that, with some slight exceptions of threatened relapse, she had

remained perfectly well ever since. She was a stout, well-preserved old lady, accustomed to live rather freely, and of gouty tendencies. She thought that the present attack had been produced by an unexpected exposure to cold air in her passage, but about this there might be much doubt. I had only to recommend a more persevering use of the same remedies, and I believe they were again soon successful.

Erysipelatoid Eczema of face and hands from exposure—Repeated attacks in a healthy boy.

[Continuation of case of Master Bennett, whose portrait is kept at College of Surgeons.]

I did not see this boy again until three years after my last note. He was then brought to me suffering from another very severe attack. Both hands and his face were covered with a bullous, eczematous eruption. The bullæ were formed by the coalescence of a number of vesicles. By the sides of his fingers many of them were ruptured, leaving abrasions. The eruption, although most severe upon his hands and face, was not absolutely confined to these parts. There were some vesicles on his chest and a few on the abdomen. They were, for the most part, discrete; but here and there arranged in groups. I was told that the present eruption had been threatening for about ten days, but that it had developed suddenly in its present severity, apparently in consequence of a long ride on his bicycle on the previous day. The boy did not appear to be particularly ill, and what little disturbance of health was present was probably entirely due to the irritation of the dermatitis. I was told that during the three years that had intervened since his last attack, he had been almost wholly free; at any rate he had had no severe outbreak. Occasionally a few spots had threatened, and his mother had thought it necessary to give him the medicine which I had prescribed, and to which she attributed his cure. This medicine consisted of an antimonial mixture containing a sixteenth of a grain to the dose. His mother thought that the threatenings of relapse had usually been in the spring, and it is to be noted that we have recently had unusually

warm weather for the season, followed by cold and east winds. I suggested that the inflammation of his hands and face was probably due to the irritation of sun and wind during his bicycle ride; but I was assured that he had worn gloves. It is a point not to be forgotten that he is a boy of a very fair, delicate skin, and that his face is freckled in a most unusual degree. In the intervals of his attacks his skin had been perfectly well. Thus the disease showed no tendency whatever to lapse into chronic eczema. It seems probable that the case should rank as one of a congenital susceptibility of skin, and not as a catarrhal disease. I was in the first instance somewhat inclined to the latter diagnosis; but that the attack on the present occasion has been induced by exposure to wind and sun is, I think, tolerably certain. It is not an ordinary "summer eruption," for it does not persist during the whole of summer, nor is it worse in the hottest weather.

Pityriasis Rubrum, or Eczema Universale?

Mr. —, æt. 60, February, 1887. It is desquamative, or peeling, and not weeping. In this feature it differs from eczema. It is absolutely universal. From the fingers and palms the skin is peeling in thick flakes. Everywhere else the skin is branny. His feet and legs are swollen, and perhaps there is a little swelling of the skin generally. Nowhere, although the skin is very red, is there any positive moisture. It comes nearest to moist eczema in the clefts of the groins and at the anus. It itches somewhat, especially if he is stripped in the cold. He sometimes wakes scratching. I ordered alkali, with aconite and lead and tar-wash. He is no better after a fortnight's trial of it. It has desquamated more, and has spread to the hands and feet. He does not easily perspire, but feels very weak, and on two occasions in bed has sweat profusely.

Tongue nearly clean. Urine scanty and bowels costive.

In speculating as to the cause of this severe attack, we may take into account the following facts:—

He is of gouty family, and has himself been threatened. Indeed, one great toe has been aching in a suspicious way

since the attack began. Against the idea of gout, however, is the fact that for three years he has been a total abstainer, and has always lived carefully.

He tells me that in early and middle life he used to perspire very easily, and, being fond of exercise, used to sweat much. Three years ago he noticed a change in this respect, finding that his skin did not so easily become moist. He then took to Turkish baths, of which he became very fond.

Acute general Pruriginous Eczema in an old man.

I saw with Dr. S——, at his residence in Kensington, an old gentleman of 94, who in his youth had served with Wellington in Spain. Until within a few weeks of my seeing him he had been able to take his daily walk in the park, and had enjoyed fairly good health. He was now suffering from prurigo of such severity that he was praying for death. In spite of chloral and opiates, his nights had been almost sleepless. Dr. S—— told me that when the prurigo first set in there was little or nothing to be found on the skin, but now, under the influence of scratching, &c., almost the whole surface had become erythematous, and here and there there was pitting on pressure, more especially on the legs. On the most careful inspection I could not find any papules, nor any evidence of bites. A single pediculus had been caught some months ago, but since then the most careful search had been repeatedly made without result. I was told that the eruption had first shown itself on his feet. Although I have called it erythema, it was really eczematous in many parts. As yet no papules whatever had been produced by scratching; indeed he had been in the habit of rubbing rather than scratching. There was a history of gout in the family, but our patient himself had been very abstemious, and had for some years drank almost solely milk.

I advised that our patient should constantly keep in bed, and be wrapped in a weak lotion of tar and lead; that arsenic should be avoided, and that he should take much less milk. A mixture was prescribed containing an alkali with small doses of colchicum.

*General Eczema of the Aged—Illustration of treatment by
Tar.*

My friend Dr. H. D——, a not undistinguished physician, offered a good example of senile eczema. He was sixty-two years of age when it began. He had suffered for five months when he came to me, and it was gradually spreading over the whole body, limbs and face. His cheeks and ears were covered with it. It had advanced in spite of many remedies which he had tried, and was very irritable. He was a thin, spare man, with gouty and dyspeptic antecedents. I told him that it was serious, and that he had better go to bed for a time, and use weak tar lotions and take tar internally. I saw him on May 7th, and on the 12th he wrote me a letter from which the following is an extract :—

No other word than “specific” will adequately express the effect of your Tar treatment upon my eczema. Within forty-eight hours my face was practically well, and all the rest of the rash was evidently “killed.”

Considering that it had been advancing for four months in spite of much internal and external treatment, this was truly remarkable.

My wife kept me well soaked in the tar till Thursday (it was Monday afternoon before the treatment was begun). On Thursday, the raw and oozing patches on my shoulders and back were all dry, and sufficiently healed not to stick to my clothes, and my face was well; so we came home, and I had a fairly pleasant journey instead of one of absolute misery as on going up the Thursday previous. I had a fair night Thursday—was seeing patients in my consulting-room from ten till one, and did some consulting out of doors, all with comparative comfort. I have kept up the Tar, undressing and well soaking three times a day, and a bath at night. All points and hard papules are gone, only red dry patches remain. They are easily irritated, and prick and tingle, but that is all.

In this case it will be seen that although the disease began in winter, it only assumed a troublesome form when warm weather set in.

THERAPEUTICS, ETC.

No. XXXV.—*On details in prescribing the Iodides.*

From my earliest days of practice I have been in the habit of never ordering iodide of potassium without the addition of ammonia, and I have taken many opportunities of strongly advocating this custom. I learnt it, I believe, either from Sir William Gull or Sir James Paget;* perhaps from both. It has been my experience that many patients, respecting whom I was told either that they could not bear iodide of potassium or that it had failed to cure, were at once and definitely relieved by my prescription. The combination amounts possibly to giving the iodide of ammonium with iodide of potassium. Whatever the chemistry of the combination may be, however, I feel no doubt that the ammonia doubles the efficiency of the potassium salt, and at the same time does much to prevent its disagreement. During the last twenty years I have been in the habit of very frequently using another combination, of the value of which I have a very high opinion. It is the three iodides together, viz. the iodides of potassium, sodium, and ammonium. With the three in combination, some additional ammonia being of course added, I believe that a much smaller dose will accomplish the cure than with any one. I have expressed this opinion in print repeatedly, and my reason for recurring to it now is that I observe in a recent paper by Eulenberg that he has arrived at the same conclusion as regards the bromide salts in the cure of epilepsy. He uses the potassium, sodium, and ammonium salts together; and holds that in such combination they are much more efficient than would be the same dose of any one alone.

As regards the use of the iodides in general, I may say that I have always avoided, as much as possible, giving very

* See a note, by myself, in *Medical Times and Gazette*, May, 1854, p. 488.

large doses, and that I use them much less freely now than I did in years gone by. Even with the most scrupulous attention to idiosyncrasy and the careful avoidance of these salts in those patients in whom they are little less than active poisons, they are yet apt to produce in many persons, who seem to be bearing them fairly well, conditions of serious depression of nerve tone. Some patients will tell us that they always feel better when taking iodides; but others, and I think a larger number, will say that, although they find them necessary in order to control local disease, they always find themselves living in a low key whilst taking them. The few scraps of clinical experience which fall to my share in reference to the use of bromides in those liable to epilepsy, incline me to the belief that, even in that malady, the cure is often worse than the disease, and that the prevention of the attacks is only accomplished by keeping the patient permanently in a state of low tone, and inflicting serious damage upon the mental powers. *Ægreseitque Medendo.*

No. XXXVI.—*The treatment of Psoriasis.*

It is, I think, very desirable, from time to time, to place on record examples of definite success in the treatment, even of common diseases. It is as one of these that I record the following case. It was one of the most severe forms of psoriasis which I have ever seen. The patient was a man who gave his remedies a fair chance; and the results were such as very much surprised him.

Mr. B——, a robust man, aged 50, who had never known a day's illness in his life, came to me on March 13, 1893, on account of psoriasis, from which he had suffered for twenty years. It had begun on his scalp, and only during the last eight or nine years had it affected his limbs much. The patches were of all sizes, from that of peas to that of a small plate; and they were covered with silvery scales or thick, horn-like crusts. Many of those on his arms and legs showed deep fissures. Although still in excellent health, he was in a very miserable condition, and having had much specialist treatment, with but temporary benefit, he had become very

desponding. During the last few months he had done little or nothing; but in former years he had taken much arsenic. When I remarked that my treatment would be chiefly by an ointment, he replied, "But, you see, I shall need a firkin at least." The ointment which I ordered contained* chrysophanic acid, creasote, the liquor carbonis, and the ammonio-chloride of mercury; and was made up in pots of ten ounces, with the direction that he should use it very freely indeed, night and morning. He was also to soak himself every night in a hot bath containing a teaspoonful of the liquor carbonis detergens to the gallon of water. By means of this bath the scales were to be removed as much as possible before the ointment was rubbed in. He was also to take a dose containing one-sixteenth grain of tartarized antimony, every four hours.

When I saw Mr. B—— a fortnight later (in consultation with my friend Dr. Brodie Sewell), all his patches were free from scales, and the fissures were healed. The antimony had not depressed him in the least, and he felt quite well. With some slight modifications the treatment was continued. A month later, being almost well, he left off the antimony, but continued his tar-bath and the ointment. In the beginning of July, *i.e.*, about three months from the commencement of the treatment, he came to me in order to show that his skin was quite clear, and to ask for advice as to the prevention of recurrence. I then told him to keep the ointment constantly by him, and should any spots reappear, to immediately attack them.

In connection with this case, I may venture to offer the following memoranda as to the treatment of common psoriasis:—

1. In all cases alcoholic stimulants should be forbidden. Those who persist in intemperance are incurable. An ointment containing the ingredients above mentioned, varying in proportion according to the delicacy of the skin, is by far the most efficient means of treatment. It must be used very

* I have not given the exact proportions of these ingredients, because they were varied from time to time. The chrysophanic acid, which was the principal one, was in the proportion of half a drachm to the ounce, more or less, and the creasote about ten drops.

freely, without regard to the underclothing or bed-linen. The regular use of a hot bath softens the skin and prepares it to receive the ointment.

The addition to the bath of the liquor carbonis detergens, or of the carbonate of soda, or both, in the proportion of a drachm to the gallon, very much increases its efficiency.

Although arsenic exercises a specific influence over psoriasis, and is in many cases the best internal remedy, there are yet many cases in which it is better to avoid it.

Arsenic should be avoided in most cases in which the patient has taken it often and for long periods.

Tartarised antimony in small doses will be often found useful in cases not suitable for arsenic.

No. XXXVII.—*Nux Vomica as a Tonic.*

A lady, for whom I had prescribed a mixture containing the tincture of nux vomica, applied to me three years afterwards to know if there was any harm in continuing it. She had taken it during the whole time, and her testimony was: "I cannot live without the mixture. If I leave it off for a fortnight, I cannot sleep. I become nervous and as if I must cry all day long. When I take it I am in good spirits, and have fair energy."

This patient was a lady, aged 49, who inherited gout, and had a very feeble circulation. She consulted me, in the first instance, on account of symptoms of rheumatic gout, and I had been obliged to put her on a somewhat restricted diet and to advise abstinence from wine. She bore the most emphatic testimony to the improvement in her general health which had resulted, and she had got quite rid of all symptoms of arthritis. As has just been noted, however, she was unable to maintain her tone without the nux vomica. The dose which she had taken was ten minims of the tincture three times a day before meals. I have met with many patients such as the above, who found that nux vomica suited them better than any other kind of tonic, and that they could take it for very long periods without any failure of the effect. It is, I feel sure, the very best substitute for wine and beer, and is often very superior in its effects to either. Like them, it

should be considered as an article of diet rather than a medicine, and, when it agrees, it may be continued indefinitely.

No. XXXVIII.—*Dermatitis Herpetiformis with Stomatitis—Remarkable effects of Arsenic.*

Miss E. L——, aged 52, was brought to me by Mr. Hugh Smith, of Farningham, on July 7, 1891. She had been suffering since November, 1889, from a vesicating eruption on her body and limbs, accompanied by sores on the sides of her tongue and in her cheeks. The eruption on her body did not begin till August, 1890, nearly a year after the first appearance of the sore mouth. The eruption was described as having consisted chiefly of “blotches and blisters.” When she came to me it was almost confined to her legs, on which there were large reddened areas with bullæ. She had been given arsenic in combination with iodides, and was improving. Her mouth had often been so sore for a time, that she could take nothing but milk. I advised that she should abstain from iodide of potassium and take arsenic in increased doses, and in combination with opium. Six weeks later I heard from Mr. Hugh Smith that she was almost well. This good result was, however, not wholly maintained in the sequel.

Miss L—— came to me again, at my request, in August, 1893. Her report was that she had taken her medicine very irregularly. She thought that she had usually been better when taking it. She had had frequent relapses of vesicles as large as peas on the legs and arms, and sometimes also on the trunk. They would come out in many places at the same time. She said that her skin was always more painful just before the vesicles appeared than after they had developed. In this respect her eruption conformed to what is constantly observed in true herpes. She had also frequently herpetic vesicles on her tongue and lips, which were very sore. She had indeed rarely been long free from vesicles either in the mouth or on the limbs. There could be no doubt that her eruption was in the main of the herpetic type. I urged her to take her medicine more regularly, with a view of definitely

PLATE XCIX.

DERMATITIS HERPETIFORMIS.—HERPETIFORM PEMPHIGUS.

THIS portrait shows well the condition of the eruption in the case of Mrs. Esther Ann B., recorded in the last number of 'Archives.' It will be seen that the shoulders are covered by a vesicular and congested eruption, any single part of which might readily pass for a group of herpes. The progress of the different vesicles also much resembled that of shingles, for they dried up, leaving thin, dark crusts. The history of the case (given at page 10 in detail) is that the patient suffered, during at least seven years, from relapses of the eruption, and that it was always cured for the time by arsenic. The final result is not known. The eruption avoided the loins, the genitals, and the upper parts of the thighs (patient's statement), but, with these exceptions, was present on almost all other parts. It appeared probable that the arsenic would in the end effect a complete cure; for on the last occasion she had remained one year without any relapse. The case no doubt belongs to the group described by Dr. Duhring as *Dermatitis herpetiformis*. Its real relationship would, I believe, be indicated by the name *Pemphigus herpetiformis*.

See also Plate C., in which the details of the eruption are depicted on larger scale.

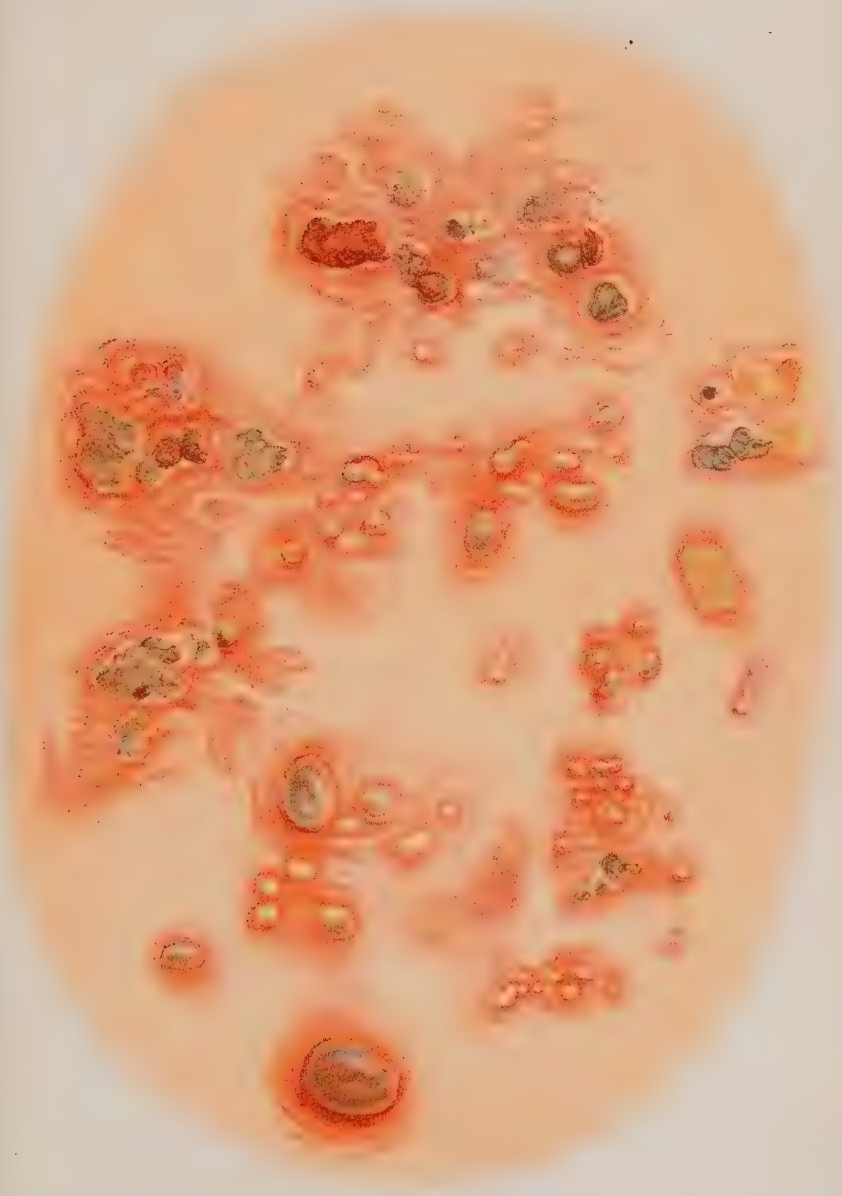




PLATE C.

DERMATITIS HERPETIFORMIS.

THIS Plate is a careful study of the eruption in the preceding case. The vesicles, bullæ, and crusts are shown. It will be seen that the vesicles do not tend to coalesce so much as is usual in herpes, and that they present very various stages at the same time. Some of them are large enough to constitute small bullæ, and around all there is very vivid congestion.



testing its power in preventing the eruption. I gave her a fresh prescription for larger doses of arsenic.

A fortnight after I had increased the arsenic, Miss L—— wrote to me: “As soon as I began taking the medicine, the places that I complain of began to come out. Now they are all over my legs, arms, and body. They have not formed into blisters; but the burning and irritation are intense, and at times almost unbearable. The medicine also seems to affect my eyes and makes them burn, and they are inflamed. I have taken the medicine quite regularly.”

Miss L—— called on me again a month later. On August 29th I noted:—I saw her last on August 1st. She had then one blister on the right elbow. The skin was quite sound elsewhere. I ordered Liq. Sodæ Ars. m iv., Liq. Arsenicalis m ij. in Tinct. Aurant., with m iv. of Cascara. Immediately after beginning this medicine the eruption began to spread, and a week later, when she went to Eastbourne, it came out profusely. Her limbs and trunk were covered, *her face, hands, and feet escaped, as always before*. She continued the medicine regularly. The skin burned intolerably, and her eyes were irritable. The eruption consisted of erythematous patches, which spread at their edges and covered large areas—in fact, involved the whole surface. These patches were swollen and distinctly œdematous. She shows me to-day, after taking the arsenic one month, the remains of these patches. They still pit on pressure at their aggressive borders. They have subsided and become pale in their centres. A peculiarity of the present attack is that there has been no vesication. Usually the development of blisters relieves the burning. Her tongue is furred. She feels faint, sick, and sinking at times. Has had very bad nights. Any food, even a glass of milk, induces a burning heat in the skin as if scalded. The bowels have been regular. She can read, but not for long. Eyes not red; lower eyelids a little puffy; black freckles. She speaks as if a little hoarse. Advised to take half-doses.

On Sept. 28th, under the smaller doses of arsenic, Miss L—— was absolutely free from her eruption and in good health.

GOUT AND RHEUMATISM.

No. XXXIII.—*Calcareous bands in the Corneæ in association with Gout.*

In a recent number of ARCHIVES I described (perhaps for the first time) the formation of minute tophi in the iris. Since then I have carefully inspected the eyes of many gouty subjects, but have not found another instance of it.

There is a very peculiar and very rare condition of disease of the cornea occasionally seen in gouty patients. It consists in the deposit of a broad white band which crosses the front of the cornea horizontally. It is usually symmetrical, and so superficial that it may be scraped away, without causing any damage to the substance of the cornea. It is chemically the sodium urate. Its subjects are always gouty persons, although, not infrequently, the proof of extant gout may not be very definite. This condition was, I believe, first described by Mr. James Dixon. I have myself seen and recorded several examples of it, and some have been published by Mr. Nettleship and other observers. I now publish another case, taken from an old note-book. The condition is so rare, that I have not for many years seen an example of it.

It is of much interest to note that neither in the deposits in the iris nor in those which form bands across the cornea is any inflammation produced. The deposit appears to take place quite quietly; and we also note as a feature common to both, that the influence of light seems to have some effect in locating the deposit. The corneal bands are always in that part of the cornea least covered by the eyelids; and the same statement is true of both eyes in the only case in which I have seen the iris affected. In this instance the upper part of the iris, where covered by the upper lid, was quite free, and

the lower portion, where partially protected by the lower lid, was almost so, the largest deposits occurring opposite the canthi, just where most constantly exposed to light.

The following are the brief notes of the case which has been the occasion of my making the above observations.

In February, 1874, I saw a man named Higgs, aged 41, who had these transverse bands on both corneæ. The other parts of the corneæ were clear. I have preserved no note as to history of gout, but the following items of evidence are not unimportant. He had for long habitually used atropia, and in both eyes there were pupillary adhesions, and in the left the lens was opaque. He had not seen well since boyhood, and although he had never had any attack of inflammation, he had often, about the age of 27, had the eyes red and irritable. These are precisely the usual concomitants of the iritis of inherited gout. I saw the man only once.

No. XXXIV. — *Effect of Exercise as a guide to diagnosis in arthritic maladies.*

A test which is often very useful in reference to the diagnosis of the rheumatic or gouty origin of arthritis, is the influence of exercise upon the pain and stiffness. Patients with serofulous joints, or with synovitis of a non-rheumatic character, often find it quite impossible to use the joint; whilst, on the contrary, those who suffer from chronic rheumatism are usually relieved by exercise. This is by no means an invariable result, but it is sufficiently definite to be of great value in practice. The gouty rheumatic pain, known as lumbago, may, as is well known, almost invariably be dissipated by resolute exercise.

In illustration of these remarks I may quote the case of a lady of 35 who was sent to me on account of stiffness and pain in her knee-joints. The question was whether she ought to rest them or not. The joints were but little swollen, but both of them creaked very definitely on movement. The patient had also creaking in other joints, *e.g.*, shoulder and wrist. She told me that her knees often felt so stiff that she could scarcely walk, and the attempt to do so always gave her

pain; but she added, "I can always walk off the pain," and "I have been to dances when I had so much pain and stiffness that I could scarcely move, but have got quite well during the evening, and the next day have had little or no pain." With such a history I felt no hesitation in advising that the patient should continue to take as much exercise as she could, and on no account to be persuaded to rest. Although there was no recognised history of gout, Miss H—— said that her father had suffered a good deal from pains in his joints. She said that her own joints were always more comfortable in weather which was either very cold or very hot, and always worse when the air was damp or during the prevalence of east winds. It is just one of the cases which may end in a general crippling, but I feel sure that the evil day will be deferred by resolute exertion. Were the patient allowed to take to her couch, the joints would rapidly stiffen.

No. XXXV.—*The relationships of Gout and Rheumatism.*

I have long held that by far the principal clue to the interpretation of the relationships between gout, rheumatic gout, and rheumatism, is to be found in the laws of hereditary transmission. In reference to this I have also endeavoured to point out the importance of recording details as to various members of the same family, and have ventured to suggest that those engaged in a country practice might often find good opportunities of rendering service to science in this direction. In consultation practice we but too often see only fragments of cases, and it occurs to us but very rarely to be consulted by many members of the same family. An exception to this has just happened to myself, for I have been made acquainted with the fact that five persons, who at different periods during the last twenty years have been under my care and of whose cases I have taken notes, are brothers and sisters. In addition to these five, all of whom are elderly, I have seen several of the next generation. It is known that on the father's side there is a history of true gout, the father himself having suffered from several attacks. It is

not thought, however, that the tendency existed in any very intense form.

The first case, which I will relate, is that of a fine old lady, Mrs. C——, aged seventy and the subject of *morbus coxæ senilis* on both sides. She is the youngest of the family. There were originally twelve, and although, as I have said, she is seventy, she still has seven brothers and sisters living, the family being remarkable for longevity during several generations. I have seen Mrs. C—— twice, first in 1882, and secondly during May of the present year. She came to me in the first instance with stiffness and pain in her left hip, which were then of two years' duration. She appeared to be in excellent health; but was liable to attacks of thrombotic purpura in her legs with œdema. In early life she had been accustomed to take malt liquor and to live generously. She was exceedingly active in parish affairs. I sent her to Droitwich, and prescribed various remedies for her arthritis. Eleven years later she came to report progress, and suffering from another attack of œdema of the legs. She was still a cheerful, hale old lady, florid and very stout. She told me that the pain in her left hip, which had been very severe when I saw her before, had gradually ceased, but that the joints had stiffened, and the limb lengthened. She illustrated the fact of lengthening by stating that it was quite impossible to kneel with the two knees bearing equally on the same cushion, for that the left thigh appeared to her at least an inch and a half longer than the other. She was so stout, that I did not care to undertake the almost hopeless task of ascertaining the cause of this. In probability it was due to tilting of the pelvis. She had of late years had a high-heeled boot made for the other limb. When the pain ceased in her left hip, her right began to suffer, and both had now become very stiff. She could still hobble about by the help of a stick and her daughter's arm, but was so lame that she scarcely ever walked, and she could neither lie down flat in bed nor sit back in her chair. She habitually sat on the edge of the chair, and in bed was propped up in a half sitting position. None of her large joints, excepting her two hips, had suffered; but the joints of her fingers, especially the terminal ones, were much deformed

and stiffened. I could not detect any chalk stones. Her nails were not of the ordinary gouty type, but thin, soft, and fluted. She said they had been so all her life; but I was inclined to suspect that their condition was in part due to the acro-arthritis from which she suffered. Her arteries were dilated and her pulse was firm. She was not in the least deaf, and said that deafness was not in her family. Since my first recommendation of Droitwich, she had visited repeatedly not only that place but Buxton and Bath, and averred with emphasis that she had never derived the slightest benefit from any of them. Nothing, she said, had ever done the least good. Whilst at Buxton she had had an attack of acute gout in her foot, the only one from which she had ever suffered. One of her sons had had an attack of rheumatic fever; but, with this exception, none of her four children had as yet shown any definite tendency to arthritis. I have only to add respecting this patient that she began to suffer from rheumatism in her hip soon after a change of residence to a somewhat damp locality not far from the Thames, where she had continued to live ever since.

Mr. C—, aged 33, the son of this patient, consulted me on account of pain and stiffness in many of his joints. He said that he was quite well so long as he was taking violent exercise, but that he got stiff if he sat down. He had recently been obliged to give up malt liquor because he thought it made his joints worse. He had once been in bed a week with what was called “a threatening of rheumatic fever,” and he had once suffered an attack of quite painless discharge from the urethra, which the doctor, whom he consulted, said was not a true gonorrhœa, but a consequence of gout.

Mr. R. F—, an old gentleman of seventy, of feeble circulation, was under my care in May, 1891, for rheumatic gout in his left knee. He had also some stiffness of his finger joints. He told me that kidney disease, diabetes, and albuminuria were in his family, and that his father had suffered from true gout. He was Mrs. C—’s brother.

Mrs. M—, an old lady of seventy-two, a sister of Mrs. C—, in excellent preservation, came to me in August, 1891, on account of chronic rheumatism in both hips and in her right shoulder.

NOTES ON CANCER AND CANCEROUS PROCESSES.

Senile Freckles with deep Staining—A superficial Epithelioma on the Cheek.

I add the following to other cases recently recorded in my ARCHIVES which illustrate the connection between senile freckles and epithelial cancer.

Mrs. J——, aged 71, was sent to me in April on account of a “papilloma” on her face. The disease consisted in a very superficial patch of rodent on her left cheek. It was as big as a shilling, and although it showed some scar and a slightly-marked rodent edge, it could not be said to be ulcerated. I was told it had been present two years or more. My interest was especially attracted to the case from the circumstance that the old lady was the subject of senile freckles. Her lower eyelid, and especially that of the left side, showed groups of freckles of large size, and almost black in colour. They had not coalesced so as to form patches of melanotic staining, but in size they closely approached to that condition, and, after all, the difference is probably only one of degree.

Senile Freckles and Epithelial Cancer in association with them. —Disappearance of Keloid in old age.

An old gentleman of 72, Mr. G——, who consulted me many years ago on account of a large keloid scar on his back, has recently (June 1, 1893) come again under my observation, on account of hydrocele. He has now senile freckles on his hands and nose, and, in association with them, a warty, rodent ulcer on the latter. A point of much interest is that his keloid, which was of long duration, has entirely softened away. The site is now occupied by a supple, bluish scar, as big as an outspread hand. The keloid had followed a burn, and had persisted nearly twenty years.

Melanotic Staining of Lip.

Mr. W——, aged 41, has a black stain on the mucus membrane of his lower lip as big as a sixpence, not quite round, and not very definitely margined. It has been there for a year at least, and is increasing. There is not the slightest thickening or soreness, but he formerly had sore lips from tertiary syphilis. He is in an early stage of the condition illustrated in Mr. Willett's remarkable case.

Melanotic Staining of Mucous Membrane of Lip.

There is a model in the St. Louis Museum in Paris, which represents exactly the same state of things as that which I have described in Mr. Willett's case, ARCHIVES, Vol. IV. p. 62.

The mucous membrane of the lower lip is affected. There is very extensive coal-black staining. This involves the lining of almost the whole lip. It is staining only: there is no thickening and no ulceration. In the middle, however, there is a growth, as big as a nut, deeply ulcerated, and, although apparently not pigmented in its substance, quite black at its edges.

This specimen is numbered 443, XLVII, and was placed in the museum in 1877 by M. Vidal. No history is given in the catalogue. It is named "Sarcome Mélanique de la Lièvre."

There was also a drawing shown in the Vienna Congress Museum (Leopold Bauhofer), in which melanotic staining was associated with a cancerous growth. It was designated "Carcinoma faciei."

Melanoid Staining of Prepuce with Melanotic Sarcoma.

Another remarkable instance of the association of melanoid staining with cancerous growth came under my observation in the person of a gentleman from near Winchester. The part affected was the prepuce. The prepuce could not be retracted; but a large patch of deep brown staining, abruptly margined, was seen passing from its mucous surface over the free edge upon the skin. Its base was infiltrated and very hard, the induration ceasing abruptly at the corona. The glans could not be exposed to view. There was much dirty discharge from under the prepuce.

There was no history that the melanoid staining had long preceded the growth; but the patient had been very unobservant, and the fact that there was a growth at all had only been discovered by his surgeon (Mr. Roberts, of Twyford), who had been called in to pass a catheter. The old gentleman held that both the staining and the growth had commenced together, about six months previous to my seeing him. There was no evidence of any gland implication, or of deposits in the viscera, and I recommended that immediate operation should be performed, for which purpose he returned home.

Mr. Roberts, in the operation, found that the prepuce alone was involved in the growth. The latter consisted of a thick mass, in part pigmented, in part not so. It is the first case of melanosis of the prepuce which I have seen.

Malignant Disease of the Thyroid Gland—Very rapid growth.

I saw Mrs. P——, aged 56, in consultation with Dr. Roland Smith, on October 9, 1891. For the past two months she had noticed a swelling in the neck, rapidly growing, but quite painless. I found a large fixed mass of almost stony hardness adherent to the sternum. One nodule projected between the sternal and clavicular heads of the sterno-mastoid muscle.

Dr. Roland Smith was good enough afterwards to report to me. His patient had died on November 27th, that is, about two months after our consultation, and within four of her having first noticed that her collars were tight on her neck. The swelling had increased before her death, but had not caused permanent obstruction either to the trachea or œsophagus. She had, however, experienced attacks of painful breathlessness, and had become very feeble. During the last week of life she had fainted several times, and there had been a condition of permanent cyanosis. Her death was finally quite sudden. Dr. Smith's belief was that the cause of death was pressure involving the pneumogastrics, one or both, and that it certainly could not be attributed to exhaustion.

Sebaceous Cysts of Scalp assuming Sarcomatous characters.

With a label "Molluscum Generalisé, Tumeurs Atheromateuses," there is in the Museum of the St. Louis Hospital

a model which shows, if I mistake not, the same condition as that in two others which I have described (see ARCHIVES III. 336). It is No. 859 in XXXIII. In the Catalogue, the term "Molluscum" is very properly omitted, and the designation stands, "Tumeurs atheromateuses—Face et crâne." The tumours are evidently solid, and many of them much congested. Many occur on the temple and face. These features wholly separate the case from one of ordinary sebaceous cysts. No history is given, but I have little hesitation in assigning the case to the group referred to, of which it makes a third.

Lupus on the face in two aged persons—Cancer of the Scar in both.

A few weeks after I had seen the patient at the Kensington Workhouse whose case I have previously described, an old woman presented herself at the Stamford Street Hospital whose condition was so exactly similar that I had some difficulty in persuading myself that she was not the same individual. She was near eighty years of age, and her whole face was covered with symmetrical bat's wings of superficial lupus. Her alæ nasi were notched, and the tip of the nose destroyed, and in the middle of one cheek, on the lupus scar, there was a round patch of cancerous growth. The conditions of the latter were exactly like those in the Kensington patient, the border being slightly elevated (like rodent), and the centre presenting low fungating granulations. The main difference between the two patients was that in one the cancerous patch was on the left cheek, and in the other on the right. The old woman said that her lupus had begun, not on her nose, but on the cheek, almost in the exact position of the patch of cancer. The lupus had begun about twelve years ago, and the cancer not till ten years later. There was no gland disease. The patient had suffered somewhat from rheumatism, but had in other respects enjoyed excellent health through her long life. She knew of no history of scrofula or consumption either among her relatives or her own children. One ear was wholly involved, on all parts, by the extension of lupus from the cheek, but the other ear was quite free, and showed nothing in the concha.

MISCELLANEOUS.

No. CVII.—*Against Trouser-Pockets.*

A very important precaution in all cases of chancre is to instruct the patient to remove everything from his trouser-pockets. Coins or keys, or both, carried so as to press upon the groins, are very apt to irritate the inguinal glands, and if the latter are inflamed, to increase the risk of their supuration. Patients who suffer from varicose veins in the leg, should also be warned in like manner. The impediment to the return of blood, which any weight in the pocket will easily cause, may constitute a not unimportant source of aggravation to the discomfort which attends varices. It would indeed be a decided improvement in dress if the trouser-pockets in front were abolished. In addition to what I have mentioned, it is to be remembered that cases of varicocele and of neuralgia of the testis, as well as all forms of orchitis, are liable to be much irritated by coins in the trouser-pocket.

No. CVIII.—*On estimating the Symptom of Pulsation*

It is not unimportant to note that in estimating the symptom of pulsation when it is very feeble, the eye is a far better judge than the hand. A feeble beating which cannot be perceived by the fingers or by the outspread hand, may sometimes be recognised at a glance by the eye. This especially applies to tumours communicating with the skull, and I cannot illustrate it better than by quoting the following instance of it. A child, six years old, was brought to me with the anterior fontanelle much depressed, and it was a question whether it was or was not closed. Her mother

assured me that when the child was nervous she could see it beating, but on the most careful examination by the touch I failed to detect any pulsation. I tried the tips of the fingers and the flat palm, and tried the lightest possible pressure as well as firmer; but although now and then I might have fancied that it beat, I could not feel sure. The membrane was stretched so tightly across that I had even an impression that it was ossified. A few minutes after concluding this very careful, but wholly negative, tactual examination, I could see the whole space pulsating quite vigorously. Again I tried the fingers, and again with the same negative result. A surgeon who was in consultation in the case received the same impressions as myself; by the hand it was impossible to perceive it, but to the eye it was very conspicuous. I have repeatedly noticed the same in cerebral tumours and in cases of exposure of the cerebral membranes, and am convinced that it would often save much trouble to abstain from any attempt at feeling for pulsation, and trust to the eye. At any rate, the use of the eye should never be omitted where the presence or absence of pulsation is in question. There are, of course, mechanical means by which the eye may be assisted, such as fixing a little flag as a lever over the suspected swelling, but they will seldom be necessary.

No. CIX.—*Chronic Balanitis.*

There is a very peculiar form of balanitis, which in my experience occurs only to middle-aged or elderly men. The balanitis which is so common in boys and young men from neglect of washing, is, I think, always a diffuse inflammation of the preputial sulcus. That to which I now refer as peculiar to those advanced in life, occurs always in abruptly margined patches. The affected areas are as abruptly margined as the islands on a map, and they are remarkably persistent. This form of balanitis is a rare affection, even in the aged; for in the latter, as in the young, the diffuse form is much the more common. Diffuse balanitis may usually be cured very quickly by free irrigation with hot water, or by the use of some weak astringent lotion. The map form, however, resists, not only

these simple measures, but almost every kind of ointment or lotion that can be devised. I have had under care some very marked examples of it, and they have always been very obstinate. At page 18, Vol. II. ARCHIVES, I have recorded two examples of this condition, under the name of balanitis perstans. The form which I there described was one in which the patches would become red and glazed, there being exceedingly little evidence of secretion. This dry state is, however, not an invariable condition.

I have just seen, in consultation with Dr. Burnett, of Wimpole Street, a widower, aged 60, who has been annoyed for a year past with this balanitis in patches. It has been sometimes better and sometimes worse, never quite well. When at its worst the patches secrete pus freely; and at no time do they present the dry, glazy condition which I described as a peculiarity in my former paper. In Dr. Burnett's patient there is no special cause to be assigned. He is in good health, and has not been able to observe that anything in his diet influences the condition. He had, as was the case with other patients, tried a variety of remedies without success, before I was consulted.

No. CX.—*Scabies affecting the Glans Penis.*

It is not so generally known as is desirable that the eruption of scabies may affect the glans penis. Whether the sarcoptes can really burrow and live in a moist mucous membrane I do not know. It would seem very improbable. That, however, an eruption may occur on the glans, in connection with scabies, is most unquestionable. As it is attended by superficial ulceration and the formation of crusts, it might very easily lead to an error in diagnosis. I have just seen such a case. A gentleman, aged 31, was covered from neck to foot with scabies, in all stages from minute vesicles to ecthyma. Although the irritation had been extreme, the diagnosis had been missed, and the disease had been present for three months. There were three crusted sores on his glans penis, each as large as a fourpenny-piece; and deceptively like non-indurated chancres. The inguinal lymphatics were slightly enlarged.

The occurrence of scabies on the glans penis is well acknowledged by French authorities, and there are in the museum of the Hôpital St. Louis several excellent models which show it.

No. CXI.—*Perforation of the Septum Nasi.*

A lady of sixty, the widow of an officer, consulted me on account of disease in her nose. I found a perforation in the septum, through which the tip of the finger might have been passed. Everywhere its edges were soundly healed, excepting posteriorly. The ulceration here appeared to be still progressive in the cartilage itself. There was no swelling of the mucous membrane, simply a narrow, grey, ashy line in the middle of the edge. On taking hold, with forceps, of the sloughy tissue, I found that it adhered quite firmly and clearly involved the cartilage. My impression is that this disease not unfrequently begins in the cartilage itself, and involves the mucous membrane only secondarily. It seldom shows any tendency to spread on the surface of the latter, and it almost always ends anteriorly with the cartilage, leaving the columna nasi untouched. Thus patients may have large perforations without any falling down of the tip of the nose. When the disease is syphilitic it tends to involve all structures alike, and the tip of the nose usually falls. In the present instance there was not the slightest external deformity of the nose. I applied nitric acid to the unhealthy border of cartilage. There were no indications of syphilis in the case. This patient during the last three years had twice suffered attacks of epistaxis which had necessitated plugging of the nostrils; but they had probably had nothing to do with the ulcerated septum.

No. CXII.—*Abscess simulating Malignant Disease.*

I have recently (June 1, 1893) seen a case of a tumour under the upper part of the sterno-cleido-mastoid, which I at first took to be a lympho-sarcoma; but it proved to be an abscess. The conditions under which this occurred were somewhat peculiar, and a memorandum of the case becomes

somewhat important for diagnosis. The patient was a very robust man, aged sixty-four, who had lived freely, and had never suffered from any form of struma. He had, however, sixteen years ago, had a lump form in the same place, for which he consulted the late Mr. Spence, of Edinburgh, and was for a time very anxious about it. This lump disappeared after a time under Mr. Spence's treatment. I had attended, about a year ago, a brother of the patient, for epithelial cancer of the tongue, attended by enlarged glands. The lump, for which I was consulted, had been forming about a month, and quite painlessly. It was a rounded mass, as big as a fist, and adhered to the adjacent parts. There were no enlarged glands to be detected near it. Handling the tumour gave no pain. I thought that there was a deeply seated sense of fluctuation; but upon this point opinions differed, and, on the whole, I was inclined to believe that it was a soft solid. As the diagnosis was doubtful, I sent the patient for a fortnight to the seaside, and administered iodide of potassium. When he returned at the end of the time, the tumour had increased in size, and there was a little reddening on its surface. I now felt no doubt as to there being fluctuation, but still thought it very possible that it was a malignant growth, which had suppurated. An incision, however, let out a large quantity of thick matter, which showed no mixture of broken-down tissue. Under poulticing, with the use of a drainage tube, the swelling rapidly subsided; and when Mr. B——, at the end of a fortnight, returned to his home, it appeared likely that he would soon be well.

The progress of the abscess in this case made it certain that it was neither of strumous or malignant origin, but leaves us quite in doubt as to the exciting cause. There was a remote history of syphilis (twenty years ago), and it appeared possible that the present attack was due to relighting of disease in a gland, which had been formerly enlarged. There was, however, nothing of the nature of a gumma on the present occasion.

No. CXIII.—*The Cardiac Sleep-start.*

Mr. B——, the subject of nervous exhaustion, describes this

symptom. He was previously quite familiar with the ordinary sleep-start (of muscular system), and says that this is quite different. Just as he gets to sleep he wakes with a feeling as if his heart was stopping, lifts his arms, and struggles for breath. At first there was a sense of impending death, but he has got used to the attacks, and is now not alarmed. They occur not only on going to sleep in bed, but if he falls asleep on his couch. They are followed by palpitation. There is no cardiac murmur. Mr. B—— is very decidedly out of tone. Once in the night he had an attack of unexplained shivering. He is married and has lost sex-desire. He is dyspeptic and liable to acidity. I make no doubt that the attacks are dependent upon deficient tone and nervous irritability, and should suspect sexual exhaustion in an over-worked man as the primary cause.

No. CXIV.—*Rider's Sprain.*

What is known amongst riders as the "rider's sprain" is, I believe, usually a rupture of part of the adductor magnus. It occurs when, in consequence of sudden emergency, the rider attempts to take a too vigorous grip of his saddle. The rupture is felt immediately, and is often followed by a fall. As in the case of "lawn-tennis sprains" and other ruptures of muscles, the recovery is usually almost perfect in the end, although it may be with some slight permanent weakness.

I have just seen a gentleman who told me that he had had two severe "rider's sprains," both in fox-hunting. The first of these, and much the most serious, occurred twelve years ago, and the last a few months ago. In the latter he did not fall from his horse, but was instantaneously and completely disabled in consequence of something giving way in the inner side of his thigh. He had been under treatment by bandaging, &c., ever since the accident, but was still quite unable to ride. On examining his knee I was somewhat astonished to find that there was a considerable bony mass developed along the line of insertion of the adductors, and just where he complained most of pain in connection with his second accident. It seemed probable that this had resulted from the injury

received on the first occasion. I found on inquiry that this had been more than a mere sprain, for his horse had rolled on him. It appeared certain, however, that there had been no fracture of the limb, for he had continued to walk about during the whole of the subsequent treatment. The patient was a strong, very muscular man, and probably the periosteum had been more or less detached.

No. CXV.—*Recovery from Obstruction without Laparotomy.*

Dr. Jennings, of Christchurch, records a case in which a woman of 41 was suddenly attacked by severe abdominal pain and vomiting. An elongated smooth tumour of considerable size was found in the right hypochondrium. A severe illness followed, with the usual symptoms of "intestinal obstruction," and much pain and sickness. The illness began on the 19th of September, 1891, and terminated by action of the bowels on the 23rd. There had been jaundice. The treatment had been by large enemata and morphia, with "cautious manipulation" of the tumour. The recovery was complete, and the large tumour disappeared. It was probably impacted feces, possibly magnesia and possibly charcoal. It may have been a case of gall-stone colic complicating an old-standing intestinal concretion. The symptoms were sufficiently severe to have warranted a laparotomy at any stage. (*New Zealand Journal*, April, 1890.)

No. CXVI.—*Inheritance from Mother of tendency to formation of an exostosis on the first phalanx of one finger.*

An example of an inherited peculiarity, which much excited my interest on account of the very remarkable similarity in parent and child, occurred in the person of a young lady, sent to me on account of an exostosis which grew from the base of the first phalanx of her left ring-finger. It was not in the least pedunculated, but consisted of a rounded, broadish ring of bone, which projected over the dorsal end of the phalanx just above the knuckle. The

extensor tendon crossed it in a furrow in the middle. It was a slight disfigurement, but caused no inconvenience, and being close to the joint I strongly advised that it should not be meddled with. It had been slowly growing during the patient's childhood, but I assured the parents that as she had now nearly attained adult age it would probably not grow any further. No other exostoses could be detected with the exception that the upper ends of the fibulæ were both of them considerably larger than natural. The interesting point in the case, and the one that induces me to record it, is that the girl's mother had on the same phalanx of the same hand a precisely similar, though much smaller, enlargement. In her it had developed during childhood and adolescence, but had not grown in the least since she attained maturity.

Dr. Charles Oliver, of Philadelphia, has recently recorded in the *Ophthalmic Review* (with woodcuts) an interesting case in which a mother and her son were the subjects of congenital opacities on the cornea. The opacities affected both eyes, and were almost exactly alike in the two patients. It appeared probable that, although present at the time of birth, the opacities had increased somewhat subsequently. The same statement was made as regards the exostosis above recorded.

No. CXVII.—*A Note on the Uncertainties of Nomenclature.*

I have several times recently thought it worth while to draw attention to local peculiarities in the nomenclature of disease. Thus we have seen that a century ago the word "croup" would not have been intelligible in Yorkshire, and that a little before that time the designation under which fatal cases of laryngitis were registered in Scotland was that of "closing." I have also adverted to the fact that the older writers on skin diseases, even as recently as Mr. Plumb, used the adjectives "lupinosa" and "favosa" for eruptions quite different from favus, to which alone modern writers would apply them. In corroboration of this latter statement, I take the following from a work published in 1833, by Mr.

George Macilwain, on "The Constitutional Origin of the various forms of Porrigo, commonly known by the names of Scald-head, Tinea, Ring-worm, &c." Mr. Macilwain writes, "The Porrigo Lupinosa has been with me a rare disease, and I believe it is not a very common variety in this country; but a very bad case of it yielded just as readily as any other to attention to the general health." It is remarkable that this author should have thought that scald-head and ring-worm were curable by constitutional treatment, but it may be taken as certain that no benefit would result to a case of true favus. The explanation of Mr. Macilwain's success, if he had it, was probably to be found in the circumstance that he was very attentive to cleanliness, and that he did actually use local treatment which was effectual, whilst he chose to attribute all the results to his constitutional measures. I am justified in saying this, because, after having spoken most depreciatingly of local treatment, he writes (see page 81), "I, prefer ung. hydrar. nitrat. variously diluted according to the susceptibility of the surface to which it is to be applied." And on another page he writes, "The local treatment is simple, yet each part of it should be carefully executed, regardless of the trouble it requires." Now the simple truth is that "the ointment of the nitrate of mercury variously diluted," but used, as it evidently was, as strong as the patient's skin could bear it, is one of the most efficient remedies that we possess. The man who was removing all crusts, "regardless of trouble," and applying this ointment, had no right whatever to infer anything as regards the share taken by his constitutional measures. I must admit that it is even possible that he might obtain an apparent and temporary cure of a case of favus. It is a point which we may mention with much satisfaction that we have during the last half-century advanced to a clear knowledge that all the maladies mentioned are for the most part, and usually altogether, local: but although we have added some important remedies to our pharmacopœia, we still have possibly none which are more useful than that with which Mr. Macilwain inadvertently cured his patients.

The word *gout* is one which we are apt to believe has

always had one and the same meaning. I much doubt, however, whether it was not by some persons and in some places in former days used as a name for rheumatism. In the records of the Kilmarnock Registrar, from which I have several times quoted, I have observed a number of entries which state that the cause of death was "gout." Thus, Elizabeth Gray, aged 40, wife of a thatcher, died of "gout"; and Marion Richmond, a young woman only 22, the daughter of a bonnet-maker, was also registered as having died of "gout." Now gout is supposed to have been very rare in Scotland, but, whether common or not, it is almost incredible that persons of these ages, and in these stations of life, should have died of it. In all probability, it is acute rheumatism that is meant. I do not think, however, that true gout was so entirely unknown in Scotland as some authors would have us to believe, for Sir Walter Scott, who was an authority, repeatedly mentions it, and in connection with wine-drinking habits.* It may be added that in the Kilmarnock Register by far the greater proportion of those alleged to have "died of gout" were women.

It is, I suppose, generally known by English surgeons that on the Continent the word "Struma" means Bronchocele. It was so used in England formerly, and such is its meaning in the quotation which I gave at page 384 of Vol. IV. So also in France "Nævus" means any form of Mole.

No. CXVIII.—*Gouty Phlebitis—Recovery after Obstructive Thrombosis and suspected displacement of clots.*

The danger of detachments of fibrinous clots in the course of phlebitis is well known. It is not, however, an event which is frequently encountered in practice. When it occurs, and when the clot finds its way to the heart, it is probably almost invariably fatal. Mr. Skey has published the details.

* The word "gout" is supposed to be derived from the French, *goutte*, a drop, and that, in turn, from the Latin, *gutta*. Shakespeare mentions "gouts of blood." It is, therefore, applicable to any disease which might be considered due to "defluxion."

of one such case, and the late Dr. Ormerod, of Brighton, many years ago showed me an excellent specimen of a clot entangled in the valves of the heart in the Museum of the Sussex County Hospital. I have never myself known a case in which this accident was supposed to have occurred and in which the patient recovered. One such, however, has been reported to me under circumstances more or less trustworthy. A gentleman aged 38, of gouty history and large veins, was confined for nearly six months to his bed by obstructive phlebitis in the right lower extremity. He told me that on two occasions during this illness he had very nearly died with extreme difficulty of breathing and pain at his heart, and that his medical attendant had diagnosed a detached clot. It was probable that the deep veins of the limb had been affected, for his legs remained afterwards liable to œdema. Considering the great frequency of obstructive phlebitis of superficial veins and the extreme rarity of these accidents, we may probably assume that there is not much danger when they alone are involved. Many gouty persons suffer from repeated attacks of this affection, and are by no means careful to observe the recumbent posture during any long periods.

No. CXIX.—*Purulent Phlebitis implicating cavernous sinuses.*

Case XII., in Dr. Bright's second volume, is a good example of inflammation of bone from injury, suppuration of diploe and between bone and dura mater, extension backwards to both cavernous sinuses, and finally to subarachnoid spaces at base of brain. The patient, a man of middle age, who had been kicked by a horse, had left the hospital, but returned very ill the same evening. He died three days after the return to hospital and twenty-four after the accident. The veins in one orbit and some also in the brain were full of pus (see p. 34).

No. CXX.—*Extensive denudation-areas around optic discs, independent of Myopia and of over-use.*

An interesting example of extensive choroidal denudation around the optic disc, exactly like that of advanced myopia,

but without any material elongation of the globe, came under my notice in an old man of 72, from Yorkshire. Although he had managed to make a moderate fortune, he had never learned to read, and his eyes had never been employed upon near objects. In early life he was a sailor, and more recently a coal merchant. He assured me that, when he went to sea, he could see in the distance as well as any one. Of late his sight had failed very much. It was difficult to estimate his vision accurately; but it was certain that nothing higher than —2 D improved him in the distance, and that with this glass he could only make out about $\frac{2}{3}$ %. The two eyes were alike. In both there was a very large arcus senilis, and in both a most deceptive appearance of opacity of the lens. From an unaided inspection of the eyes I had written down "cataracts in both"; but, to my surprise, on using the ophthalmoscope I found I could see all the details of the fundus without the slightest obstruction. Finding an area of complete denudation, very abruptly margined and completely surrounding the disc, which was nowhere less than two or three times the width of the disc itself, I supposed that we had to do with high myopia, but, on testing this, found that it was very slight and, as already stated, not more than —2 D. I was so much surprised at this result that I asked my son to measure the myopia carefully. This was done with the same results which I had myself obtained. In each eye there was a group of fine pigment spots at the yellow-spot region; and to senile degeneration in this part, it appeared probable that his defect in vision was chiefly due. There was also a little haze in each lens, although, as stated, not enough to prevent a perfect inspection of the details of the fundus.

No. CXXI.—*Rupture of Muscle simulating a tumour*
—*Remarkable instance of erroneous history given*
by patient.

Colonel C— was sent to me on account of a tumour which was supposed to be growing in the front of his thigh. He was a stout, robust man, aged 60. In the middle of the front of his right thigh there was a lump, about as large as

half a small orange, which was evidently attached to the quadriceps muscle. It was ill-defined, but of considerable hardness. It had been doubted whether it were attached to the bone or not, but on this point I felt no doubt that it certainly moved with the muscle. I was struck with the fact that there seemed to be a hollow in the middle of the quadriceps just below the swelling, and, thinking that the latter might be consequent on rupture of the muscle, I inquired as to any accident. This my patient, who was a very intelligent man, entirely denied. He had, he said, discovered the lump almost by chance about a month ago. Under these circumstances I advised him that he should have the swelling explored by an incision, and freely excised if it should seem desirable. The next day, however, I received a letter informing me that he had remembered an accident of considerable severity which had happened about six months ago. He had slipped down a flight of five steps in his garden when they were covered with ice. He wrote, "I thought I had broken my leg, and it was several minutes before I could get up. I was then lame for several days, but gradually got better." On learning this, I requested another visit before sanctioning an exfoliation. On a more careful examination I convinced myself that the swelling really was the stump of a ruptured rectus muscle. It moved with all movements of the muscle, and there was a very distinct trough of considerable size extending down the middle of the thigh immediately below it. It is needless to say that I advised that, for the present at least, all thought of operation should be given up.

It is not the first time that I have known the contracted end of a torn muscle assume conditions which led to the suspicion of a tumour, but I have never before known a patient entirely forget the history of the accident which had caused it. In this instance the patient admitted that, after his fall, he had to be carried into his house, that he was confined to his couch for several days, and that he had been lame ever since; yet in the hurry of the moment, when the question was first asked, he had forgotten all about the occurrence. It may be added, in explanation, that he was

a man whose thoughts were constantly occupied by very important engagements. The case adds another to the numerous, and frequently repeated, instances which warn us of the danger of trusting to the impromptu statements of patients. Always ask again after time for reflection has elapsed.

No. CXXII.—*An exceptional form of Dupuytren's Contraction.*

Different examples of Dupuytren's contraction of the palmar fascia present, occasionally, very remarkable features and special peculiarities. In a gentleman, whom I saw a few weeks ago, the contraction was strictly limited to the little finger of each hand, which was drawn down until its tip touched the palm. He could straighten his ring fingers perfectly, and I could not detect any induration of the fascia in the palm itself. There could not have been a more conclusive demonstration of the now well-known fact that the tendons are in no way affected. The condition was most precisely symmetrical. The contraction was caused chiefly by a single strong band from the ulnar border of the finger, which passed from its base to near its tip. There was no history of tendency to this malady in his family, but the patient was of a gouty stock, and had himself, on a single occasion, had an attack of gout.

It is of great interest that in these aberrant forms we see the condition developed with exact symmetry. In such a case as the above we can attribute nothing whatever to local influences. The patient had used neither tools nor playthings; nor, if he had, would it have been likely that both hands would have been affected alike. What the constitutional influence may be which sets this contraction of fascia going, it is very difficult to say. That it is in some way connected with the hereditary tendency to gout, and in an especial manner with hereditary tendency to itself, there can be little doubt. Yet, as regards gout, we may freely acknowledge that it is by no means a direct manifestation, but is connected with it only as a sort of offshoot, having its analogues in certain forms of tissue change which are undoubtedly asso-

ciated with hereditary gout, but not with lithiasis or tendency to the formation of tophi. The almost absolute exemption of the female sex is a very remarkable feature.

No. CXXIII.—*Case illustrating prognosis in Heart Disease.*

A case of some interest in reference to the prognosis of heart disease came under my observation in connection with a form of chronic eczema on the extremities. A railway inspector, aged 50, in good health, consulted me concerning the state of his hands. He had scaly, thickened, and peeling patches in the palms of both hands and between his fingers, and some red patches on both legs. On the latter positions the disease had been present for nearly two years, and everywhere there was some tendency to papillary growth and thickening. The patches on his hands had appeared only within the last nine months. The chief interest of his case, however, concerned the state of his heart. His heart was much hypertrophied in connection with obstructive valvular disease. There was no history of special cause, for he said that he had never had rheumatism. The disease had been recognised from youth, and at the age of seventeen he had been taken to Sir William Gull for advice. He himself attributed it to his having in early life been accustomed to run to trains, &c. He said that he had often sat in the railway carriage panting for twenty minutes before he could recover his breath. His life had been refused at no fewer than six different insurance offices, and, although he had always been able to continue his active occupation, he had consulted many physicians. For many years he had been in the habit of carrying nitrite of amyl about with him, and he had formerly suffered severe and protracted attacks of angina. For two years past he had been quite free from these attacks. His immunity coincided with the appearance of his eczema.

No. CXXIV.—*Inflammation of Submaxillary Gland*
—*Suspected Calculus.*

A man, aged about 40, apparently in good health, was sent to me with a considerable swelling of his right submaxillary

gland. It had given rise to suspicion of a new growth. Along the floor of his mouth there was considerable swelling, and Wharton's duct appeared to be much thickened. I thought that I could detect a calculus in it, and my son, who was with me, shared the impression. The swelling had been present for some weeks. I made a very free incision along the course of Wharton's duct into the indurated structures, and, although at first I thought I had struck a mortary concretion, I was in the end obliged to abandon the search, being unable to remove a calculus. The result, however, was quite satisfactory. When the man came up to me ten days later the swelling had very much subsided; and two or three weeks later still I heard from his surgeon that it was not necessary for him to come up again, as the swelling of the gland had quite disappeared.

I have repeatedly removed calculi from Wharton's duct in cases of inflammatory engorgement of the submaxillary glands, but I never had one in which the relief was so definite and so prompt as in this case; yet it is difficult to see how the incision should by itself have done much to give relief. The question remains whether the calculus did really escape and was lost. Although this is possible, I confess that I do not think that such was the case. Whether or not, the case still strongly supports the surgical view to make an incision whenever there is any suspicion of the presence of a calculus. Had I not felt too confident in my diagnosis, I should have passed a probe down the duct and sounded for the calculus before using the knife. In any case it is wise to take this precaution. I have more than once detected calculi by sounding, not only in the submaxillary but in the parotid gland.

No. CXXV.—*On partnership Causation in reference to the Eruption known as Urticaria pigmentosa.*

Another excellent example of successful results from the investigation of disease after the manner that I have recommended is offered by the disease known as urticaria pigmentosa. I hope that I am guilty of no misrepresentation of

the present creed of our best dermatologists if I say that this malady exists for them as a very rare and, as regards cause, quite mysterious one. It is possible that some may have called it *sui generis*. The student of combinations is not, however, satisfied with a bare diagnosis and a name. His process of reasoning is somewhat as follows: First, he avails himself of the well-known fact that an urticarious wheal may, in quite healthy persons, result from various forms of local irritation, nettle-stings, flea-bites, &c. Secondly, he calls to his aid the fact that the skins of young persons develop the urticarious wheal very easily and freely. Thirdly, he remembers that urticarious susceptibility to local irritation varies very much in different individuals, and that in some it is so excessive as to amount almost to an idiosyncrasy. A fourth consideration is, that under the laws of pathological habit certain influences of transitory duration tend, if frequently repeated, to produce more or less lasting results. Fifthly, as regards pigmentation he gives attention to the circumstance that the readiness to deposit pigment in the tissues is often a peculiarity of the individual, having relation to his complexion, &c., whilst in all persons long-continued irritation and frequent congestion of the skin is sure to lead to it in some degree. Sixthly, certain persons, especially certain children, are beyond all their companions attractive to fleas, gnats, bugs, &c., and liable to suffer from their attacks. These six postulates having been granted, we are almost in a position to foretell the occasional development of such a condition of skin as that under investigation. Given a child attractive to fleas, very prone to urticarious dermatitis, with much movable pigment in the blood, and what is more probable than that his flea-bite urticaria should become persistent and his skin brown? The picture may be made yet more complete by supposing that the child scratches without control, and that he is under circumstances which expose him in an especial manner to the attacks of parasites, whilst but little has been done for his protection.

Those who demur to the theory of external irritation being the exciting cause of urticaria pigmentosa, suggest with

truth that there are thousands of flea-bitten children who never develop this condition, that fleas are very common and this malady very rare, that fleas in the majority cause no urticaria at all, and there is in the subjects of the malady usually no clear proof of unusual exposure to the supposed cause. All these objections are due to forgetfulness of the laws of partnership. It is most true that amongst the children of the poor it is very common to see the skin speckled over with the little petechiæ left by flea-bites without the slightest trace of urticaria. In these, one element in the partnership—the proneness to urticarious inflammation—is absent. If it were not that the coming together in the same child of the several peculiarities which have been named were a very rare coincidence, urticaria pigmentosa would be far commoner than it is.

This hypothesis, of a seldom-occurring combination of certain individual peculiarities with local irritation as the cause of urticaria pigmentosa, may be submitted to tests of its probability. If it be the correct explanation we ought to expect half-developments of the malady—cases, to wit, in which some of the elements of partnership are omitted; we ought also to encounter ill-marked examples of it, and those ought perhaps to be more common than the extreme ones, and we ought to find that the malady itself ends when the conditions terminate. Now each one of these propositions is true. We do meet with not a few children whose skins are more or less pigmented and thickened from frequently recurring local irritation, but in whom the malady never attains the dignity of a name. We do also see some children who suffer terribly from flea-bite urticaria, but who never become pigmented. We do find that urticaria pigmentosa ceases as a rule when the child, by advancing years, becomes no longer so attractive to fleas, nor so liable to urticaria from irritation. We have further its precise analogue in adult life, and especially in senility, in which, from the irritation of body-lice and scratching, the whole integument may, in exceptional cases, become thickened, harsh, and almost black with pigment. What *Melasma a pediculis* is for the old man (see Hebra's portrait), urticaria pigmentosa

is for the child. There is no mystery about the causation of either. Each is in turn the result of a combination of causes, which are severally easy of recognition.

No. CXXVI.—*Operations for Hernia two centuries ago.*

From Cooke's "Marrow of Chirurgery," fourth edition (1685), which may be held to represent the state of English Surgery in his day, the following is an extract:—

"OF CUTTING FOR RUPTURES.—This operation is seldom used because hazardous and dreadful. 'Tis performed, either when what is fallen into Scrotum cannot be reduc'd, or to hinder their falling and so to cure, in both which the party is to be first tyed fast to a Form or Table. In the *First*, when the Guts cannot be reduced, either from the hard'ned *Fæces* there, or the narrowness of the passage; make the incision in the upper part of the Scrotum, not touching the Guts, then with the *Directory* put in at the Incision and under the production of the peritoneum with your Knife cut so much as is necessary towards the Belly. After Reduction stitch up so much of the *Peritoneum* as may suffice to hinder the fall of anything into Scrotum after it is cicatriz'd. But perform not this, unless strength be sufficient, much less what follows."

Cooke then proceeds to describe the operation for radical cure in non-strangulated cases. It will be observed that he does not mention any other form of hernia than inguinal, and that when operating for strangulation he clearly contemplated obliteration of the sac.

No. CXXVII.—*Dupuytren on Early Operations for Hernia.*

I extract the following from an account of the improvements in surgical practice which had been recently effected at the Hotel Dieu, communicated by Dupuytren to Dr. Ratier. It refers to the first quarter of the present century: "Hernia are now operated upon, so soon as patients enter the hospital. . . . The number of deaths (from all causes) has

diminished, it is one in eighteen, nineteen, or twenty in common years; the operation of lithotomy succeeds in five-sixths, that for hernia in three-fifths, that for cataract in seven-eighths," &c., &c.

No. CXXVIII.—*An example of temporary Xerostomia.*

As a rule, xerostomia, when once developed, is permanent; or, if it undergoes any amelioration, it is only partial, and after the duration of some years. As a rule, also, xerostomia occurs only in women. A gentleman who consulted me, about a year ago, on account of sciatica, afforded, however, an exception to both these statements. Unfortunately I have only his own description of his symptoms, and it is quite possible that there may be some fallacy in his narrative. He stated that he had had an attack of dry mouth, which lasted one month, during which his tongue was swollen, and the whole of his mouth so dry that he was obliged to occupy himself constantly in sipping water or sucking ice. Previously to this occurrence he had been accustomed to a very moist mouth, and the condition, when I saw him, was perfectly normal. The attack passed off spontaneously.

No. CXXIX.—*Profuse Perspiration as a symptom.*

A young gentleman, who was about to be married, called to consult me in reference to that event. I had treated him for syphilis three years previously; but, as he had remained perfectly well ever since the disappearance of the secondary symptoms, there was no reason to suspect that he was in any degree under the influence of taint. During the last two years he had taken no medicine, and had not had a symptom. He had up to quite recently enjoyed excellent health, and had been accustomed to take a great deal of exercise—rowing, hunting, &c. The arrangements for his marriage had entailed a great deal of business trouble. One of his near relatives had been very ill, and he had also been anxious, in reference to his old syphilis, as to whether he was doing right to marry. Under this combination of depressing conditions

he had become very weak, his special symptom being a remarkable proneness to perspire. He told me that if he had to write a letter on any matter involving responsibility, it would cause him to break out into a most profuse perspiration, that the slightest exertion would make him sweat, and that in bed he would often lie awake for hours together with his nightshirt soaked. I asked him if he were suffering from sexual irritability or emissions, and he replied, "Oh dear no, I am far too weak for that." Yet, in spite of his sense of extreme lassitude, I could not detect any indication whatever of disease, and he was in good spirits, and not in the least nervous. He assured me that his symptoms had come on quite recently, and that they were due to the causes mentioned. He also felt confident (after my assurance that his syphilis was a thing of the past) that he would, when the worry of his marriage was well over, soon regain his tone. It is as an example of functional disturbance of the perspiratory glands, reaching an unusually high degree, that his case has its chief interest.

No. CXXX.—*Good Health in a man the subject of inherited Syphilis.*

A case of some interest, as illustrating the assertion long ago made that those who recover from hereditary syphilis in infancy often display no tendency whatever to chronic ill-health, came under my observation a few weeks ago. The patient was a gentleman aged twenty-six, whom I had treated in infancy for syphilis. He got well, and remained so until December, 1877, when he was sent to me with an attack of severe keratitis. I prescribed iodide of potassium and grey powder, and saw him only once. When he came to me recently he brought the letter, which I had written to his surgeon in 1877, from which I extract the following expressions. "I fear the keratitis will be very troublesome; it is severe, and will prove a long attack. If it is gone in three or four months he must be well content."

The recovery of his eyes was almost perfect. When I saw him the other day he could, making an allowance for myopia,

see quite well. His left pupil was very large, possibly from the too free use of atropine during the attack ; but the mydriasis was not attended by any loss of accommodation. He told me that his eyes had recovered in about the time that I had led him to expect, and that during the sixteen years which had since elapsed he had never ailed anything. It is remarkable that neither his physiognomy nor his teeth showed anything suspicious, and, had I not been previously acquainted with his history, I might have felt it difficult to believe that he was the subject of taint. A sister, six years older than himself—the only other living child—had also suffered from inflammation of her eyes ; but was now in good health.

No. CXXXI.—*Obstruction of the Long Saphena Vein by enlarged glands.*

The following narrative may be read in connection with what I have written at page 163 against trouser-pockets :—

I saw, with Mr. Garry Simpson, at East Acton, a young man of 22, who was supposed to have phlebitis of the long saphena vein in the whole of its course. I was told that the vein could be easily traced by the finger as a piece of thickish cord, beginning in Scarpa's triangle, and passing down to the ankle. The patient was in bed when I examined him, and I was at first disappointed that I could not find what had been described to me. Only with difficulty could I detect the vein at all with the finger, though a greenish streak on the inner side of the thigh made its position quite apparent to sight. The patient suggested that he should stand up, assuring me that I should find it easily then. This proved to be the case. In the erect position I could trace the vein through the whole length of the limb. It felt as if about the size of a cedar pencil, but it was not very hard. Nothing in the least like it could be discovered in the opposite limb. Our patient was suffering from an acute gonorrhœa, and there were some enlarged glands below Poupart's ligament. It seemed probable that these compressed the vein at its point of entrance into the femoral, and thus prevented the return of blood. There was no reason to think that the femoral

itself was plugged, and there was no œdema of the limb. It did not seem probable, therefore, that any form of phlebitis had travelled from the pelvic organs. The vein had not been rendered in the least tortuous, but I had little doubt that its coats were somewhat thickened, for it certainly was much firmer than natural. There was besides a distinct greenish tinge over its course.

No. CXXXII.—*A doubtful Diagnosis of Ringworm of the Nails.*

In July, 1887, I treated a girl of 17, for what we then diagnosed as eczema of the nails. The history was that in infancy she had eczema of the scalp ("with a big crust"), and at that time one finger-nail had been all over little dots like pinpricks. When I saw her almost all the nails of both hands were affected, and were covered with little indurations, which were most numerous near the lunula. She had at this time no eczema of any other parts. I prescribed a bichloride wash, and gave arsenic internally, and a few months later changed the wash for a mercurial ointment. The chief interest of the case consists in the fact that six years later I learnt from her brother that the remedies prescribed had quite cured her, and that her nails had remained well, with the exception of what he described as a few little dots here and there. This brother came under my care himself on account of some scaly patches on the back of his neck and cheek, which he believed had resulted from ringworm eight years ago. He thought the sister had also suffered from ringworm, and at about the same time. It occurred to me as possible that what I had called eczema of the nails had really been ringworm.

A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

No. CLXXVII.—*The Diagnosis of different forms
of Hernia.*

QUESTIONS.

1. Is it ever difficult to diagnose between inguinal and femoral hernia?
2. Is it important to make the diagnosis?
3. How would you best avoid mistakes?

ANSWERS.

1. Yes, errors are very frequently committed, more especially in women, when a femoral hernia is of considerable size and turns up over Poupart's ligament. It is very seldom that an inguinal is mistaken for a femoral one.

2. It is very important in reference to the taxis, for the direction of pressure to reduce an inguinal hernia will entirely fail if it be femoral, and might do mischief. It matters less perhaps in the case of an operation, for the diagnosis will be rectified as it proceeds.

3. The first point is to notice whether the hernia passes in the case of a male into the scrotum, and in the case of a female into the labium. Femoral herniæ, however large, never take this direction, whilst inguinal herniæ, however small, generally show a definite tendency to it. In a man, the finger may be passed into the external ring by invaginating the scrotum, and in this way it may usually with ease be made clear whether or not the canal is occupied. If the hernia have curved over Poupart's ligament so as to conceal it, it should be gently drawn downwards, and then in nine cases out of ten it will be easily ascertained that its neck passes deeply under and not over the ligament.

No. CLXXVIII.—*Fungi attacking Plants, &c.*

QUESTIONS.

1. Is it true that, when fungi attack living plants, those only that are already diseased are assailed?

2. Give instances in proof of the assertion that young and healthy plants may be attacked by parasitic fungi?

3. Mention a good example of a fungus which attacks only dead vegetable tissue.

4. Is it probable that the vegetable parasites which attack human beings can develop in those who are in perfect health?

5. Has the age of the individual anything to do with his proneness to suffer from vegetable parasites?

ANSWERS.

1. Some fungi attack dead vegetable matter, but only immediately after its death; some that which has been long dead; some that in which the vitality has been lowered, and yet others that which is in perfect health.

2. You have but to observe a patch of vigorously growing groundsel (*Senecio vulgaris*); almost every plant that has attained the height of six inches will be found to be affected with fungus. The same is true of the smut in cornfields, which destroys the buds of plants in most luxuriant health. Numberless other instances might be given.

3. The dry rot is due to a fungus, which spreads with extraordinary rapidity in wood which has been long absolutely dead, and has been placed under certain conditions as regards the exclusion of air. Many moulds, &c., grow only in dead tissues.

4. The fungi which cause ringworm, favus, &c., will attack the most healthy individuals. When very extensive, they may cause ill-health, and thus lead to the erroneous supposition that the patient was out of health before he was attacked.

5. It would appear that very young infants are but little liable to be attacked by the fungus of ringworm or favus. It is only when the hair has attained a certain stage of growth, but still remains succulent and soft, that the ringworm fungus

can flourish in it. The epidermis becomes liable to be attacked by the fungus of pityriasis versicolor at a later period of life, and the liability persists much longer. As senility approaches, the tissues appear to become for the most part, if not wholly, exempt from the invasion of parasitic fungi.

No. CLXXIX.—*Xerodermia*.

QUESTIONS.

1. Under what names was the condition known as “Xerodermia” formerly recognised?
2. Is it always a congenital disease?
3. What are the anatomical peculiarities of the skin?
4. Are those who suffer from xerodermia liable to other special affections of the skin?
5. Is there such a condition as functional xerodermia?

ANSWERS.

1. The term “ichthyosis,” with one or other appended adjective, such as simplex, serpentina, vera, and many others, was usually applied to the disease which is now usually known as xerodermia. The latter term ought to be restricted to those forms which are universal, and attended with general dryness and inability to perspire.

2. The best marked cases are always congenital, and usually several members of the same family are affected.

3. It is probable, though it has scarcely been yet proved, that the development both of sebaceous and sudoriferous glands is defective, and that with this goes some imperfection in the formation of the rete.

4. Patients who are the subjects of congenital xerodermia are very liable to peculiar forms of eczema and prurigo. Their inability to sweat often entails great discomfort.

5. The term functional xerodermia may be suitably applied to cases in which inability to perspire comes on in a patient who has formerly enjoyed a perfectly healthy skin. It is not unfrequently associated with senility, and it is sometimes seen in young or middle-aged persons in connection with nervous disturbance. It is seldom absolute.

No. CLXXX.—*Xerostomia*.

QUESTIONS.

1. What is the meaning of “xero” as used in the names of diseases? and to what affections can it be applied?

2. What are the clinical features of the disease which has been named xerostomia?

3. Is it a curable disease?

4. In which sex is it most common?

5. What drug has been found most useful, and what are its drawbacks?

6. Is xerostomia usually attended by other indications of nervous disease?

7. In protracted cases is it followed by failure of general health?

ANSWERS.

1. It means simply “dry”; and is applicable to any disease attended by abnormal dryness of the affected surface, whether skin or mucous membrane. We have xerophthalmia, xeroderma, and xerostomia.

2. Transitory conditions of dry mouth are, of course, very common in connection with nervousness; but the term “xerostomia” is reserved for certain rare cases, in which the condition is protracted, if not permanent. The whole of the mouth is involved, lips, cheeks, tongue, palate, and even pharynx. No flow of saliva takes place during eating, and the patient is obliged to sip fluids in order to swallow her food.

3. So far as at present known, it is incurable; but in the course of years it may undergo some mitigation.

4. It is almost exclusively met with in the female sex, and usually in those beyond middle age.

5. Jaborandi, or its active principle, pilocarpine, will in some cases cause flow of saliva. Patients usually complain that, if used of efficient strength, it makes them feel very weak.

6. It is a very remarkable fact that there may be an absolute arrest of the salivary and mucous secretions of the mouth, without any other indication of disorder of the nervous

system. Most of the recorded cases have been in patients who were otherwise in fair health.

7. It is also a very remarkable fact that this arrest of salivary secretion may be protracted over years, without inducing any definite failure of health.

No. CLXXXI.—*Xerophthalmia*.

QUESTIONS.

1. What is the meaning of the term "xerophthalmia"?
2. Under what conditions is dryness of the conjunctival sac met with.
3. What cases are comprised under the term "pemphigus of the conjunctiva"?
4. Is there any name for inability to shed tears? and under what conditions is it met with?
5. Is any influence of climate or occupation observed in this affection?

ANSWERS.

1. "Xerophthalmia" is a term which has been long applied to certain cases in which the whole front of the eyeball becomes quite and permanently dry. Not only is there no flow of tears, but there is no secretion of conjunctival mucus.

2. It is usually considered that some form of chronic ophthalmia precedes the condition of dryness, such, for instance, as that induced by long neglected entropion. It is certain, however, that in the great majority of cases of relapsing or persisting conjunctivitis, no tendency to xerophthalmia is ever produced. The worst and most typical forms of the latter are almost always in association with failure of health and some form of skin disease.

3. The condition known as "pemphigus of the conjunctiva" is a form of conjunctivitis in which the palpebral sac becomes obliterated and the whole conjunctiva dry. They constitute the most marked examples of xerophthalmia. Almost always there is some form of skin disease, allied to pemphigus; but it is seldom that the patient is the subject of a well-characterised form of the latter malady.

4. By some observers xerophthalmia is divided into lachrymal and conjunctival, the term lachrymal being employed

for those cases in which the action of the lachrymal gland only is suspended. These are probably common. Inability to shed tears is in part an attribute of sex, especially when it occurs solely in connection with the emotions. It is common in the insane, and may occur also after violent mental shocks. We may doubt whether any cases occur of conjunctival without lachrymal xerophthalmia.

5. The influence of climate and occupation is probably very important. Exposure of the eyes to the glare of the sun and to the irritation of sand may be very prejudicial in this direction; and furnace-men, bakers, cooks, and others, if the subjects of skin disease on the face—psoriasis, pemphigus, or eczema—may easily become the subjects of chronic conjunctivitis tending to xerophthalmia.

No. CLXXXII.—*Confusion of Mind in the Witness-box.*

QUESTIONS.

1. A medical witness in a railway action was asked whether he did not find it difficult to explain that the man had had his lower extremities quite paralysed whilst his sphincters had remained perfect. He replied, "No; there is no difficulty in that, for the legs are lower down than the trunk." Was his answer correct?

2. The same medical witness was asked whether his client had presented any objective symptoms, and replied gravely, after some consideration, "He had a severe pain in his back." Is pain an objective symptom?

ANSWERS.

1. No; it was founded on a misconception. We have but to think of a quadruped instead of a biped to see at once that the tail and its adjuncts are really distally placed as regards the lower extremities. With the tail go the genito-urinary apparatus and the lower bowel.

2. Pain is a type of a subjective symptom, since it can be appreciated only by the patient. When, however, the proofs of its existence become obvious to others beyond dispute, it may, perhaps, be allowed to rank as objective.

No. CLXXXIII.—*Questions without Answers.*

Is it possible to have syphilis twice?

Is the period of incubation in hydrophobia a definite one?

What is paludism?

What are Laveran's corpuscles?

How long a period of isolation should be required in the case of a person who has been exposed to risk of contagion of small-pox?

If a patient has been admitted into a small-pox hospital under a mistaken diagnosis, what ought to be done?

In a case of deafness, what is proved by the fact that the patient hears a watch well on his forehead?

What special risk attends the instillation of atropine drops into the eye?

Do Jewish circumcisors use stitches?

Is there much difference in the progress of the pock after vaccination as compared with that after inoculation with small-pox matter?

What is the incubation period of chicken-pox?

Are phosphatic calculi common?

Addendum to paper on Jaundice by Suppression
(see page 122).

Dr. Francis Delafield, in a paper read two years ago before the Practitioners' Society at New York, expressed the opinion that fatal cases of jaundice without any trace of duct-obstruction were not very uncommon. He described them as having a duration of from three weeks to four months, and said that it was usual to find the bile-ducts and gall-bladder empty, and the liver itself large and bile-stained. He expressly denies, apparently as the result of careful post-mortem examinations, that there is in these cases any evidence of inflammation of the duodenum or common duct. He describes the course of the jaundice as being exactly that of common jaundice, popularly known as "catarrhal," and states that the patient may have had two or more attacks before the fatal one.*

* Dr. Delafield's paper has come to my knowledge too late to allow of my putting this reference to it in its proper place at page 122.



PLATES XCVI. & CI.

NÆVUS OF FACE CURED BY CAUTERISATION.



My favourite method for the treatment of nævi on the face, and in all positions where the avoidance of scar is important, is by the repeated use of the actual cautery. These two portraits show the condition of the same child before treatment and after cure by this means. I may assure the reader that there is not the slightest exaggeration in the second one. The cautery (Paquelin's) had been used repeatedly at intervals of about two months.



PLATE XCVII.

PEMPHIGUS IN SECONDARY SYPHILIS.

THIS Plate represents a case of acute pemphigus, which occurred as the exanthem in the secondary stage of syphilis. The bullæ were exceedingly well characterised and very large. The eruption covered the arms and legs with bullæ, but on the trunk it caused only erythematous patches. It was said to have exactly resembled chicken-pox at the time of its first appearance. The chancre was still present, as also some very hard glands in the groins, and ulceration of the tonsils. The early treatment had been neglected. The treatment proved very difficult. Iodide of potassium made the eruption worse, and mercury did not cure it. When, at length, arsenic was given simultaneously with mercury, but not in combination, then very satisfactory results were obtained. The patient is, however, still, at the end of two years, not perfectly well. He is in good health, but the eruption tends to return, unless the two specifics are continued. The case is recorded in detail in 'Archives,' vol. iv., page 195.



